

**UNITED STATES  
SECURITIES AND EXCHANGE COMMISSION  
Washington, D.C. 20549  
Form 10-K**

(Mark One)

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

For the fiscal year ended December 31, 2024

or

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

For the transition period from \_\_\_\_\_ to \_\_\_\_\_

Commission file number: 001-31826

**Centene Corporation**

*(Exact name of registrant as specified in its charter)*

**Delaware**

(State or other jurisdiction of incorporation or organization)

**42-1406317**

(I.R.S. Employer Identification Number)

**7700 Forsyth Boulevard**

**St. Louis,**

(Address of principal executive offices)

**Missouri**

**63105**

(Zip Code)

**Registrant's telephone number, including area code: (314) 725-4477**

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

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

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

**None**

(Title of Class)

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

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

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

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

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

Large accelerated filer	<input checked="" type="checkbox"/>	Accelerated filer	<input type="checkbox"/>
Non-accelerated filer	<input type="checkbox"/>	Smaller reporting company	<input type="checkbox"/>
		Emerging growth company	<input type="checkbox"/>

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

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

If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statement of the registrant included in the filing reflect the correction of an error to the previously issued financial statements.

Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to §240.10D-1(b)

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 30, 2024, was \$34.9 billion.

As of February 14, 2025, the registrant had 496,044 thousand shares of common stock issued and outstanding.

**DOCUMENTS INCORPORATED BY REFERENCE**

Portions of the Proxy Statement for the registrant's 2025 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

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

All statements, other than statements of current or historical fact, contained in this filing are forward-looking statements. Without limiting the foregoing, forward-looking statements often use words such as "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "target," "goal," "may," "will," "would," "could," "should," "can," "continue" and other similar words or expressions (and the negative thereof). Centene Corporation and its subsidiaries (Centene, the Company, our or we) intends such forward-looking statements to be covered by the safe-harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe-harbor provisions. In particular, these statements include, without limitation, statements about our expected future operating or financial performance, changes in laws and regulations (including but not limited to, renewal and modification of the enhanced advance premium tax credits associated with the Marketplace product), market opportunity, competition, expected contract start dates and terms, expected activities in connection with completed and future acquisitions and dispositions, our investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, such as Part I, Item 1. "Business," Part I, Item 1A "Risk Factors," Part I, Item 3. "Legal Proceedings," and Part II, Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations."

These forward-looking statements reflect our current views with respect to future events and are based on numerous assumptions and assessments made by us in light of our experience and perception of historical trends, current conditions, business strategies, operating environments, future developments and other factors we believe appropriate. By their nature, forward-looking statements involve known and unknown risks and uncertainties and are subject to change because they relate to events and depend on circumstances that will occur in the future, including economic, regulatory, competitive and other factors that may cause our or our industry's actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance, or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

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

- our ability to design and price products that are competitive and/or actuarially sound including but not limited to any impacts resulting from Medicaid redeterminations;
  - our ability to maintain or achieve improvement in the Centers for Medicare and Medicaid Services (CMS) Star ratings and maintain or achieve improvement in other quality scores in each case that could impact revenue and future growth;
  - our ability to accurately predict and effectively manage health benefits and other operating expenses and reserves, including fluctuations in medical utilization rates;
  - competition, including for providers, broker distribution networks, contract reprocurements and organic growth;
  - our ability to adequately anticipate demand and timely provide for operational resources to maintain service level requirements in compliance with the terms of our contracts and state and federal regulations;
  - our ability to manage our information systems effectively;
  - disruption, unexpected costs, or similar risks from business transactions, including acquisitions, divestitures, and changes in our relationships with third-party vendors;
  - impairments to real estate, investments, goodwill, and intangible assets;
  - changes in senior management, loss of one or more key personnel or an inability to attract, hire, integrate and retain skilled personnel;
  - membership and revenue declines or unexpected trends;
  - rate cuts, insufficient rate changes or other payment reductions or delays by governmental payors and other risks and uncertainties affecting our government businesses;
  - changes in healthcare practices, new technologies, and advances in medicine;
  - our ability to effectively and ethically use artificial intelligence and machine learning in compliance with applicable laws;
  - increased healthcare costs;
  - inflation and interest rates;
  - the effect of social, economic, and political conditions and geopolitical events, including as a result of changes in U.S. presidential administrations or Congress;
  - changes in market conditions;
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- changes in federal or state laws or regulations, including changes with respect to income tax reform or government healthcare programs as well as changes with respect to the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act (collectively referred to as the ACA) and any regulations enacted thereunder, including the timing and terms of renewal or modification of the enhanced advance premium tax credits or program integrity initiatives that could have the effect of reducing membership or profitability of our products;
- uncertainty concerning government shutdowns, debt ceilings or funding;
- tax matters;
- disasters, climate-related incidents, acts of war or aggression or major epidemics;
- changes in expected contract start dates and terms;
- changes in provider, broker, vendor, state, federal and other contracts and delays in the timing of regulatory approval of contracts, including due to protests and our ability to timely comply with any such changes to our contractual requirements or manage any unexpected delays in regulatory approval of contracts;
- the expiration, suspension, or termination of our contracts with federal or state governments (including, but not limited to, Medicaid, Medicare or other customers);
- the difficulty of predicting the timing or outcome of legal or regulatory audits, investigations, proceedings or matters, including, but not limited to, our ability to resolve claims and/or allegations made by states with regard to past practices on acceptable terms, or at all, or whether additional claims, reviews or investigations will be brought by states, the federal government or shareholder litigants, or government investigations;
- challenges to our contract awards;
- cyber-attacks or other data security incidents or our failure to comply with applicable privacy, data or security laws and regulations;
- the exertion of management's time and our resources, and other expenses incurred and business changes required in connection with complying with the terms of our contracts and the undertakings in connection with any regulatory, governmental, or third party consents or approvals for acquisitions or dispositions;
- any changes in expected closing dates, estimated purchase price, or accretion for acquisitions or dispositions;
- losses in our investment portfolio;
- restrictions and limitations in connection with our indebtedness;
- a downgrade of our corporate family rating, issuer rating or credit rating of our indebtedness; and
- the availability of debt and equity financing on terms that are favorable to us.

This list of important factors is not intended to be exhaustive. We discuss certain of these matters more fully, as well as certain other factors that may affect our business operations, financial condition, and results of operations, in our filings with the Securities and Exchange Commission (SEC), including our quarterly reports on Form 10-Q and current reports on Form 8-K. Due to these important factors and risks, we cannot give assurances with respect to our future performance, including without limitation our ability to maintain adequate premium levels or our ability to control our future medical and selling, general and administrative costs.

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## SUMMARY OF RISK FACTORS

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

- Failure to accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs could have a material adverse effect on our business;
  - Any failure to adequately price or anticipate demand for products offered, anticipate changes to the competitive landscape or any reduction in products offered for Medicare Advantage and in the Health Insurance Marketplace may have a material adverse effect on our business;
  - Our Medicare programs are subject to a variety of unique risks that could adversely impact our financial results;
  - Risk-adjustment payment systems make our revenue and results of operations more difficult to estimate and could result in retroactive adjustments that have a material adverse effect on our business;
  - If we are not successful in procuring new government contracts or renewing existing government contracts, or if we receive an adverse finding or review resulting from an audit or investigation, our business may be adversely affected;
  - We derive a portion of our cash flow and gross margin from our prescription drug plan (PDP) operations, for which we submit annual bids for participation. The results of our bids could have a material adverse effect on our business;
  - Our encounter data may be inaccurate or incomplete, which could have a material adverse effect on our business and ability to bid for, and continue to participate in, certain programs;
  - Increases in our pharmaceutical costs could have a material adverse effect on the level of our medical costs and our results of operations;
  - Ineffectiveness of state-operated systems and subcontractors could adversely affect our business;
  - If state regulators do not approve payments of dividends and distributions by our subsidiaries to us, we may not have sufficient funds to implement our business strategy;
  - We derive a significant portion of our premium revenues from operations in a number of states, and our business could be materially adversely affected by a decrease in premium revenues or profitability in any one of those states;
  - Competition may limit our ability to increase penetration of the markets that we serve;
  - We operate in a highly competitive, dynamic and rapidly evolving industry and our failure to adapt could negatively impact our business;
  - If our third-party vendors fail to meet their contractual obligations to us or fail to comply with applicable laws or regulations, our results of operations may be adversely affected and we may be exposed to brand and reputational harm, litigation and/or regulatory action;
  - If we are unable to maintain relationships with our provider networks and timely update our provider directories, our profitability may be materially adversely affected;
  - If we or our third-party vendors are unable to integrate and manage information systems and networks effectively, our operations could be disrupted;
  - A failure in or breach of our operational or security systems, networks or infrastructure, or those of third-party vendors with which we do business, including as a result of cyber-attacks and other data security incidents, could have a material adverse effect on our business;
  - We may be unable to attract, retain or effectively manage the succession of key personnel;
  - An impairment charge with respect to our recorded goodwill, intangible assets and real estate portfolio could have a material impact on our results of operations and shareholders' equity;
  - If eligibility for the enhanced advance premium tax credit for Marketplace members expires without renewal or the eligibility for the credit is modified or delayed, our results of operations, financial condition, and cash flows could be materially and adversely affected;
  - Reductions or delays in funding, changes to eligibility requirements for government-sponsored healthcare programs in which we participate, and any inability on our part to effectively adapt to changes to these programs could have a material adverse effect on our business;
  - Significant changes or judicial challenges to the ACA and the other government-sponsored healthcare programs in which we participate could materially and adversely affect our business;
  - Negative public perception of the managed care industry, including industry practices, could adversely affect our business, operating results, cash flows and prospects;
  - Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could force us to change how we operate and could harm our reputation and business;
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- Our ability to provide services and support to manage our members' pharmacy benefits face regulatory risks and uncertainties which could materially and adversely affect our business;
  - We have been and may from time to time become involved in costly and time-consuming litigation and other regulatory proceedings, which require significant attention from our management and could adversely affect our business;
  - If we fail to comply with applicable data privacy and security laws, regulations, rules, standards and contractual obligations, including with respect to third-party vendors that utilize sensitive personal information on our behalf, our business could be materially and adversely affected;
  - If we fail to comply with the extensive federal and state fraud, waste and abuse laws, our business could be materially and adversely affected;
  - We might be adversely impacted by tax legislation or challenges to our tax positions;
  - Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity;
  - Adverse credit market conditions may have a material adverse effect on our liquidity or our ability to obtain credit on acceptable terms;
  - We have substantial indebtedness outstanding and may incur additional indebtedness in the future. Such indebtedness could reduce our agility and may adversely affect our financial condition;
  - Previous or future acquisitions may not perform as expected and we may not realize the financial results expected from acquisitions or divestitures;
  - We may be unable to successfully integrate our existing business with acquired businesses and realize the anticipated benefits of such acquisitions; and
  - Our business and results of operations may be materially adversely affected if we fail to manage and complete divestitures.
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## Non-GAAP Financial Presentation

The Company is providing certain non-GAAP financial measures in this report as the Company believes that these figures are helpful in allowing investors to more accurately assess the ongoing nature of the Company's operations and measure the Company's performance more consistently across periods. The Company uses the presented non-GAAP financial measures internally in evaluating the Company's performance and for planning purposes, by allowing management to focus on period-to-period changes in the Company's core business operations, and in determining employee incentive compensation. Therefore, the Company believes that this information is meaningful in addition to the information contained in the GAAP presentation of financial information. The Company strongly encourages investors to review its consolidated financial statements and publicly filed reports in their entirety and cautions investors that the non-GAAP financial measures used by the Company may differ from similar measures used by other companies, even when similar terms are used to identify such measures. The presentation of non-GAAP financial measures is not intended to be considered in isolation or as a substitute for the financial information prepared and presented in accordance with GAAP.

Specifically, the Company believes the presentation of non-GAAP financial measures that excludes amortization of acquired intangible assets, acquisition and divestiture related expenses, as well as other items, allows investors to develop a more meaningful understanding of the Company's core performance over time.

The tables below provide reconciliations of non-GAAP items (\$ in millions, except per share data):

	Year Ended December 31,		
	2024	2023	2022
GAAP net earnings attributable to Centene	\$ 3,305	\$ 2,702	\$ 1,202
Amortization of acquired intangible assets	692	718	817
Acquisition and divestiture related expenses	82	70	213
Other adjustments <sup>(1)</sup>	(117)	464	1,540
Income tax effects of adjustments <sup>(2)</sup>	(209)	(308)	(410)
Adjusted net earnings	<u>\$ 3,753</u>	<u>\$ 3,646</u>	<u>\$ 3,362</u>
GAAP diluted earnings per share (EPS) attributable to Centene	\$ 6.31	\$ 4.95	\$ 2.07
Amortization of acquired intangible assets	1.32	1.32	1.40
Acquisition and divestiture related expenses	0.16	0.13	0.36
Other adjustments <sup>(1)</sup>	(0.22)	0.85	2.65
Income tax effects of adjustments <sup>(2)</sup>	(0.40)	(0.57)	(0.70)
Adjusted diluted EPS	<u>\$ 7.17</u>	<u>\$ 6.68</u>	<u>\$ 5.78</u>

<sup>(1)</sup> Other adjustments include the following pre-tax items:

2024:

- (a) net gain on the previously reported divestiture of Magellan Specialty Health due to the achievement of contingent consideration and finalization of working capital adjustments of \$83 million, or \$0.16 per share (\$0.12 after-tax), net gain on the sale of property of \$24 million, or \$0.04 per share (\$0.03 after-tax), gain on the previously reported divestiture of Circle Health Group (Circle Health) of \$20 million, or \$0.04 per share (\$0.12 after-tax), gain on the sale of Collaborative Health Systems (CHS) of \$17 million, or \$0.03 per share (\$0.02 after-tax), Health Net Federal Services asset impairment due to the 2024 final ruling on the TRICARE Managed Care Support Contract of \$14 million, or \$0.03 per share (\$0.02 after-tax), severance costs due to a restructuring of \$13 million, or \$0.02 per share (\$0.01 after-tax), an additional loss on the divestiture of our Spanish and Central European businesses of \$7 million, or \$0.01 per share (\$0.01 after-tax) and gain on the previously reported divestiture of HealthSmart due to the finalization of working capital adjustments of \$7 million, or \$0.01 per share (\$0.01 after-tax).

2023:

(b) Circle Health impairment of \$292 million, or \$0.53 per share (\$0.47 after-tax), Operose Health Group (Operose Health) impairment of \$140 million, or \$0.26 per share (\$0.24 after-tax), real estate impairments of \$105 million, or \$0.19 per share (\$0.16 after-tax), gain on the sale of Apixio of \$93 million, or \$0.17 per share (\$0.12 after-tax), severance costs due to a restructuring of \$79 million, or \$0.15 per share (\$0.11 after-tax), gain on the sale of Magellan Specialty Health of \$79 million, or \$0.14 per share (\$0.11 after-tax), a reduction to the previously reported gain on the sale of Magellan Rx of \$22 million, or \$0.04 per share (\$0.02 after-tax), gain on the previously reported divestiture of Centurion of \$15 million, or \$0.03 per share (\$0.02 after-tax) and an additional loss on the divestiture of our Spanish and Central European businesses of \$13 million, or \$0.02 per share (\$0.01 after-tax).

2022:

(c) real estate impairments of \$1,642 million, or \$2.82 per share (\$2.08 after-tax), PANTHERx Rare (PANTHERx) divestiture gain of \$490 million, or \$0.84 per share (\$0.65 after-tax), impairments of assets associated with the divestitures of our Spanish and Central European, Centurion and HealthSmart businesses of \$458 million, or \$0.78 per share (\$0.60 after-tax), Magellan Rx divestiture gain of \$269 million, or \$0.46 per share (\$0.17 after-tax), Health Net Federal Services asset impairment of \$233 million, or \$0.40 per share (\$0.39 after-tax), gain on debt extinguishment of \$27 million, or \$0.04 per share (\$0.03 after-tax), increase to the previously reported gain on the divestiture of U.S. Medical Management (USMM) due to the finalization of working capital adjustments of \$13 million, or \$0.02 per share (\$0.02 after-tax) and costs related to the pharmacy benefits management (PBM) legal settlement of \$6 million, or \$0.01 per share (\$0.00 after-tax).

<sup>(2)</sup> The income tax effects of adjustments are based on the effective income tax rates applicable to each adjustment. In addition, the year ended December 31, 2024, includes a tax benefit of \$1 million, or \$0.00 per share, related to tax adjustments on previously reported divestitures. The year ended December 31, 2023 includes a one-time income tax benefit of \$69 million, or \$0.13 per share, resulting from the distribution of long-term stock awards to the estate of the Company's former CEO and tax expense of \$3 million, or \$0.01 per share, related to tax adjustments on previously reported divestitures. The year ended December 31, 2022, includes tax expense of \$107 million, or \$0.18 per share, related to the Magellan Specialty Health divestiture and a \$15 million, or \$0.03 per share, tax benefit related to the RxAdvance impairment.

	Year Ended December 31,		
	2024	2023	2022
GAAP selling, general and administrative expenses	\$ 12,400	\$ 12,563	\$ 11,589
Less:			
Acquisition and divestiture related expenses	82	69	202
Restructuring costs	13	79	—
Costs related to the PBM legal settlement	—	—	6
Real estate optimization	—	8	15
Adjusted selling, general and administrative expenses	<u>\$ 12,305</u>	<u>\$ 12,407</u>	<u>\$ 11,366</u>

## PART I

### Item 1. *Business*

#### OVERVIEW

Our mission is to transform the health of the communities we serve, one person at a time. Centene is a leading healthcare enterprise that is committed to helping people live healthier lives. The Company takes a local approach – with local brands and local teams – to provide fully integrated, high-quality and cost-effective services to government-sponsored and commercial healthcare programs, focusing on under-insured and uninsured individuals. Centene offers affordable and high-quality products to more than 1 in 15 individuals across the nation, including Medicaid and Medicare members (including Medicare Prescription Drug Plans) as well as individuals and families served by the Health Insurance Marketplace.

Centene provides access to high-quality healthcare, innovative programs and a wide range of health solutions that help families and individuals get well, stay well and be well. Our uniquely local approach – with local brands and local teams who live in, care about and directly influence the communities they serve – is a key differentiator in our ability to provide access to quality care to our members. Centene treats the whole person, an approach that is delivered locally and backed by the scale of Centene's expertise, data and resources. Through this approach and our commitment to sustainable partnerships, we work with local community organizations to realize our mission of transforming the health of the communities we serve, one person at a time.

We are focused on making strategic decisions and investments to create additional value in the short-term and to seek opportunities that position the organization for long-term strength, profitability, growth and innovation. In addition to creating shareholder value, we are modernizing and improving how we work in order to propel our organization to new levels of success and elevate the member and provider experiences.

During 2024, we operated in four segments: Medicaid, Medicare, Commercial and Other.

- **Medicaid** - includes the Temporary Assistance for Needy Families (TANF) program; Medicaid Expansion programs; the Aged, Blind or Disabled (ABD) program; the Children's Health Insurance Program (CHIP); Long-Term Services and Supports (LTSS); Foster Care; Medicare-Medicaid Plans (MMP), which cover beneficiaries who are dually eligible for Medicaid and Medicare; and other state-based programs.
- **Medicare** - includes Medicare Advantage, Medicare Supplement, Dual Eligible Special Needs Plans (D-SNPs) and Medicare Prescription Drug Plans (PDP), also known as Medicare Part D.
- **Commercial** - includes the Health Insurance Marketplace product along with individual, small group and large group commercial health insurance products.
- **Other** - includes our pharmacy operations, Envolve Benefit Options' vision and dental services, clinical healthcare, behavioral health, the TRICARE program, and corporate management companies, among others.

For the year ended December 31, 2024, our Medicaid, Medicare, Commercial and Other segments accounted for 62%, 14%, 21% and 3%, respectively, of our total external revenues. Our membership totaled 28.6 million as of December 31, 2024. For the year ended December 31, 2024, our total revenues and net earnings attributable to Centene were \$163.1 billion and \$3.3 billion, respectively, and our total cash flow from operations was \$154 million.

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

## INDUSTRY AND OPERATIONS

We provide a full spectrum of managed healthcare products and services, primarily through Medicaid, Medicare and commercial products.

### Medicaid

Medicaid is the largest publicly funded program in the United States and provides health insurance to low-income families and individuals with disabilities. Medicaid is funded jointly by federal and state governments, with the majority of funding provided by the federal government and administered by the states. Each state establishes its own eligibility standards, benefit packages, payment rates and program administration within federal standards. As a result, there are 56 Medicaid programs - one for each U.S. state, each U.S. territory and the District of Columbia. Eligibility is based on a combination of household income and assets, often determined by an income level relative to the federal poverty level. Many states have selected Medicaid managed care as a means of delivering quality healthcare and controlling costs.

Medicaid helps meet the needs of various populations through the following products and programs:

- The TANF program covers low-income families with children.
- Medicaid Expansion covers all individuals under age 65 with incomes up to 138% of the federal poverty level, subject to each state's election. The federal government pays 90% of the costs for Medicaid Expansion coverage for these beneficiaries.
- The ABD program covers low-income individuals with chronic physical disabilities or behavioral health impairments. ABD beneficiaries represent a growing portion of all Medicaid recipients and typically utilize more services as a result of their more complicated health status.
- CHIP helps to expand coverage primarily to children whose families earn too much to qualify for Medicaid, yet not enough to afford private health insurance. Historically, children have represented the largest Medicaid eligible population. Costs are primarily composed of pediatrics and family care, which tend to be more predictable than those associated with other healthcare issues predominantly affecting the adult population.
- LTSS is a Medicaid product that covers Institutional/Residential Care (Nursing and Intermediate Care Facilities) and Home and Community Based Services (HCBS) for beneficiaries requiring assistance with their activities of daily living. The largest groups receiving LTSS, by spending, are older individuals and individuals with physical disabilities, followed by individuals with intellectual and developmental disabilities, those with serious mental illness and/or serious emotional disturbance and other populations. States are increasingly turning to managed care as a solution to provide coordinated, holistic care to their LTSS beneficiaries.
- The majority of children in foster care qualify for Medicaid. The federal government has enacted legislation establishing requirements for state child welfare agencies related to the health and well-being of children in foster care, including the provision of grants and technical assistance to enable states to meet these needs and make explicit connections with Medicaid. In addition, under the ACA, former foster care children are eligible for Medicaid until the age of 26, provided that they turned 18 while in foster care and were enrolled in Medicaid at that time.
- A portion of Medicaid beneficiaries are dual-eligible, low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. According to CMS, there were more than 12 million dual-eligible enrollees in 2023. These members may receive assistance from Medicaid for benefits, such as nursing home care, HCBS and/or assistance with Medicare premiums and cost-sharing depending on their income level. Dual-eligibles use more services due to their tendency to have more chronic health issues. We serve dual-eligibles primarily through our ABD, LTSS, MMP and Medicare Advantage D-SNPs lines of business.

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

Accordingly, in an effort to improve quality of care and the affordability of healthcare, the majority of states have mandated that their TANF recipients enroll in managed care plans and many are considering moving to a mandated managed care approach for additional populations and products. CMS estimates the total Medicaid program will grow from \$877 billion in 2023 to \$1.2 trillion by 2030. Medicaid spending is projected to increase at an average annual rate of 5% between 2023 and 2030. Additionally, approximately 40% of Medicaid spend in 2023 was in Medicaid fee-for-service. Based on these trends, we believe a significant market opportunity exists for managed care organizations (MCOs) with operations and programs focused on the distinct socio-economic, cultural and healthcare needs of the uninsured population and the Medicaid populations.

We are the largest Medicaid health insurer in the country, serving 13 million Medicaid recipients in 30 states as of December 31, 2024. Our Medicaid contracts with the states of Florida and New York accounted for approximately 10% or more of our consolidated Medicaid premium revenues individually in the year ended December 31, 2024.

## **Medicare**

Medicare is the federal health insurance program for people ages 65 and over, which was expanded to cover people under 65 with certain disabilities and people with end-stage renal disease requiring dialysis or kidney transplant. Medicare consists of four parts, labeled A through D. Part A provides hospitalization benefits financed largely through Social Security taxes and requires beneficiaries to pay out-of-pocket deductibles and coinsurance. Part B provides benefits for medically necessary services and supplies including outpatient care, physician services and home health care. Parts A and B are referred to as Original Medicare.

As an alternative to Original Medicare, beneficiaries may elect to receive their Medicare benefits through Part C, also known as Medicare Advantage. Under Medicare Advantage, MCOs contract with CMS to provide services directly to Medicare beneficiaries as well as through employer and union groups. MCOs typically receive fixed monthly premium per member from CMS that varies based upon the county in which the member resides, demographic factors of the member such as age, gender and institutionalized status and the health status of the member. Any benefits that are not covered by Medicare may result in an additional monthly premium charged to the enrollee or through portions of payments received from CMS that may be allocated to these benefits, according to CMS regulations and guidance. Typically, as our Medicare Advantage members reach their deductibles and out-of-pocket maximums, our medical costs rise, creating seasonality in the business with a higher percentage of earnings in the first half of the year.

The Congressional Budget Office estimates the total Medicare market will grow from \$1.0 trillion in 2023 to \$1.6 trillion by 2030. Medicare spending is estimated to have increased 6% in fiscal 2024 and is projected to increase at an average annual rate of 7% between 2023 and 2030. Over 40% of Medicare spend in 2023 was in Medicare fee-for-service, representing a notable market opportunity to increase penetration of the Medicare Advantage products.

As of December 31, 2024, we served 1.1 million Medicare Advantage members across 37 states, primarily under the brand name Wellcare, with the highest concentration of lower-income, complex members compared to our peers. Revenues from CMS are significant to the segment. Consistent with our strategy, we have reduced our Medicare Advantage footprint to 32 states as of January 1, 2025.

### *Dual-Eligible Alignment*

Recently finalized CMS regulations are promoting greater alignment and integration for dual-eligible members across both programs, whereby full dual beneficiaries would be enrolled under the same company's Medicaid and Medicare plan, improving the quality of care and overall member experience. With over 70% of the approximately 12 million fully-eligible duals population not in fully-integrated coverage arrangements, we see significant opportunity to advance care management, improve member engagement and improve the affordability of healthcare through this process. D-SNPs offer various levels of integration of benefits, care coordination (e.g., care management), and processes (e.g., appeals and grievances, claims, materials) depending on the plan type. Fully Integrated Dual Eligible (FIDE) plans provide Medicaid and Medicare benefits, including LTSS and/or behavior health through one plan under one legal entity. Highly Integrated Dual Eligible (HIDE) plans can offer Medicaid and Medicare benefits from different plans under different legal entities owned by the same parent organization. These HIDE plans have some differences in the Medicaid benefit offering requirements compared to FIDE plans. Lastly, Coordination-Only Dual Eligible plans can coordinate care with Medicaid fee-for-service or Medicaid MCOs from different parent organizations and in some states can also serve partial dual-eligibles who do not receive full Medicaid benefits. Accordingly, we have been refining our Medicare footprint to overlap more closely with our Medicaid presence to provide D-SNP offerings that support alignment.

Newly finalized CMS regulations will require beneficiaries dually enrolled in Medicare and in a Medicaid managed care plan to receive integrated care through the Medicaid company's Medicare Advantage D-SNPs beginning in 2030, with certain restrictions beginning in 2027. We believe we are positioned well given our overlapping Medicaid and Medicare Advantage footprints and we will continue to place enterprise-level focus on the D-SNP opportunity to drive long-term growth.

### *Medicare Prescription Drug Plan*

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

MCOs contract with CMS to serve as plan sponsors offering stand-alone Medicare Part D PDPs to Medicare-eligible beneficiaries. PDPs offer national in-network prescription drug coverage, and may include a preferred pharmacy network, subject to limitations in certain circumstances. Unless CMS is notified of non-renewal and the non-renewal is effectuated by not filing a bid in June, Medicare Advantage and PDP contracts with CMS are renewed for successive one-year terms each September. Should CMS decide not to renew a contract, CMS must notify MCOs on or before August 1, and the plan would be terminated effective December 31 of that year. Our 2025 PDP bids resulted in 33 of the 34 CMS regions for which we were below the benchmarks and one region for which we were above the benchmark, compared to 30 of 34 CMS regions for which we were below the benchmark for the 2024 PDP bids.

The Inflation Reduction Act (IRA) significantly changes Medicare PDPs in 2025, most notably by eliminating the coverage gap and capping members' annual out-of-pocket cost at \$2,000 in order to provide more predictable and affordable prescription drug coverage for Medicare beneficiaries. The IRA changes effective for 2025 result in a meaningful shift in cost-sharing responsibilities between members, drug companies, CMS, and PDPs and will result in a significant increase in our premiums in consideration for our PDPs responsibility for a larger portion of total Part D benefit costs.

We served 6.9 million members as of December 31, 2024, the country's largest PDP carrier. We began providing PDP coverage in 2006 and offer stand-alone PDPs in 50 states and the District of Columbia with a priority on plans that offer low premiums, deductibles, and cost sharing.

### **Commercial**

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

The ACA created the Health Insurance Marketplace, which is a key component of the ACA and provides an opportunity for individuals and families to obtain health insurance. States have the option of operating their own Marketplace or partnering with the federal government. States choosing neither option default to the federally-facilitated Marketplace. Insurers are required to offer a minimum level of benefits with coverage that varies based on premiums and out-of-pocket costs.

Premium subsidies are provided to individuals and families without access to other coverage and with incomes above 100% of the federal poverty level to make coverage more affordable. Consumers who qualify for subsidies may choose how much of the tax credit to apply to their premiums each month, up to the maximum amount for which they are eligible. The amount of subsidy an enrollee may receive depends on household income and the cost of the second lowest cost silver plan available to enrollees in their local area. Temporary enhanced subsidies were made available by the American Rescue Plan Act (ARPA), which were further extended through 2025 pursuant to the Inflation Reduction Act.

We are the largest Marketplace carrier, serving 4.4 million members across 29 states as of December 31, 2024, under the brand name Ambetter Health. Revenues from CMS are significant to the segment.

We see an opportunity for market disruption of employer-sponsored insurance through Individual Coverage Health Reimbursement Arrangements (ICHRA). An ICHRA allows employers of all sizes to directly reimburse employees for individual health insurance premiums and qualifying medical expenses tax free in lieu of traditional employer-sponsored health insurance. The ICHRA model relies heavily on off-exchange, individual health insurance coverage as the most efficient way to use the funds. These off-exchange plans often mimic employer-provided coverage in benefit design. They are designed to provide comprehensive, consistent coverage and benefits that meet members' needs.

Using an ICHRA allows employees to tap into a more competitive health plan marketplace and a larger risk pool, creating stronger potential for lower, more stable premiums. At the same time, this approach allows employees to find products that better fit their needs. Given the full commercial group market covers over 170 million, we see a significant addressable market over the long term. We have launched plans designed to attract ICHRA membership in off-exchange plans in 6 states in 2025.

## Other

Our Other segment includes:

- *Specialty Pharmacy.* AcariaHealth offers comprehensive specialty pharmacy services customized for complex and chronic conditions through enhanced patient care offerings and collaborative partnerships with providers to optimize patient outcomes.
- *Behavioral Health.* Magellan Health, Inc. (Magellan) supports innovative ways of accessing better health through technology, while remaining focused on the critical personal relationships that are necessary to achieve a healthy, vibrant life. Magellan's customers include health plans and other MCOs, employers, labor unions, various military and state and federal governmental agencies and third-party administrators.
- *Vision and Dental Services.* Envolve Benefit Options coordinates benefits beyond traditional medical benefits to offer fully integrated vision and dental health services. Our vision benefit program administers routine and surgical eye care benefits through a contracted national network of eye care providers. Through the dental benefit, we are dedicated to improving oral health through a contracted network of dental healthcare providers.
- *Clinical Healthcare.* Community Medical Group (CMG) provides clinical healthcare, encompassing primary care, access to certain specialty services and a suite of social and other support services. CMG operates in Florida through an at-risk primary care provider model, focusing on clinical and social care for at-risk beneficiaries. Additionally, Denova Collaborative Health provides outpatient primary care and behavioral healthcare services.
- *Federal Services.* Health Net Federal Services had a Managed Support Contract in the West Region for the Department of Defense (DoD) TRICARE program. We provided administrative services to Military Health System eligible beneficiaries, which included eligible active duty service members and their families, retired service members and their families, survivors of retired service members and qualified former spouses. Our contract for health care delivery services concluded at the end of 2024.

- *Corporate Management Company.* Each of our health plans contracts with our corporate management company to provide certain functions required to manage the health plan including, but not limited to, salaries and wages for personnel, rent, utilities, population health management, provider contracting, compliance, member services, claims processing, information technology, cash management, finance and accounting and other services.

## OUR COMPETITIVE STRENGTHS

Our approach is based on the following key competitive strengths:

- *Focus and Experience.* Centene was established as a Medicaid company, anchored around long-lasting, trusted relationships, with a continual focus on low-income populations. Since our founding more than 40 years ago, we have forged new paths developing innovative solutions and addressing the evolving needs of our members, earning Centene an important seat at the table and a powerful voice to shape the conversation at the state and federal level. We have deliberately increased our market density by expanding to serve other low-income and medically complex populations and, as a result, we are now the largest Medicaid health insurer and Marketplace carrier in the country with an established Medicare presence. As states increasingly move to integrate care for individuals who are dually eligible for both Medicaid and Medicare, our expertise uniquely positions us to serve this population of more than 12 million beneficiaries nationwide. We are positioned at the nexus of affordability and choice, ready to meet the needs of consumers who increasingly seek innovative products like ICHRAs.
- *Local Approach.* Our local approach to delivering healthcare enables us to meet members and providers in the communities where they are to facilitate member access to high-quality, culturally sensitive healthcare services. Our programs and services are tailored to the unique individuals we serve and include a broad range of initiatives to address social drivers of health such as food insecurity, housing instability, unemployment and access to transportation, which contribute to health disparities among underserved communities. With local leadership owning all three lines of business, we are able to translate local best practices from our Medicaid business into product development, distribution, network and pricing decisions we make for our Marketplace and Medicare businesses. We know what our customers will value because we live and work alongside them every day.
- *Partnerships.* Centene's partnership mindset allows us to design solutions for our members that integrate the most relevant, most local and most innovative capabilities in an agile and capital-efficient way. Partnership has become both a strategy and discipline: finding, measuring and maintaining the best partners over time. Instead of owning providers, we identify the best providers for our members, investing in data and engagement models that will support them in delivering health outcomes. For example, we entered into a partnership with the National Association of Community Health Centers to enhance value-based care adoption, further strengthening Community Health Centers' ability to deliver high-quality, patient-centered care and improve maternal child health outcomes.
- *People.* Through an intentional focus on building a One CenTeam culture, we have elevated and unleashed the power of 60,500 team members who uniquely understand how to serve our members and are committed to our mission of transforming the health of the communities we serve, one person at a time.

## Benefits to Customers

We feel that our ability to establish and maintain a leadership position in the markets we serve results primarily from our demonstrated success in providing quality care while improving the affordability of healthcare, and from our specialized programs with state governments.

The following are among the benefits we provide to our government partners, providers and members:

- *Accurate and timely claims payments.* We are committed to ensuring that our information systems and claims payment systems meet or exceed state requirements. We continuously improve our claims processing strategies, expertise, configuration and tools to achieve operational excellence, including timely payments to our providers.
- *Care management for complex populations.* Through our experience with Medicaid populations and long-time presence in states with experience in long-term care for children and adolescents in the foster care system, we have developed care management, service coordination and crisis prevention/response programs that improve healthcare outcomes through decreasing preventable emergency department utilization and improving access to primary care and behavioral health intervention.
- *Commitment to quality and improved health outcomes.* We demonstrate this through obtaining health plan accreditations, such as National Committee for Quality Assurance (NCQA), which assesses the effectiveness of our structure and operational processes, clinical quality and member satisfaction. We have developed care coordination, case management and clinical programs focused on key prevention and chronic conditions. Additionally, we have launched a multi-year plan to improve quality across the enterprise with a strong focus on enhanced patient experience and access to care, which lays the foundation for strong quality ratings in the future, including Medicare Star ratings and Marketplace Quality Rating System (QRS).
- *Community-specific healthcare programs and a focus on addressing healthcare gaps.* Our expertise in government-sponsored programs has helped us establish and maintain strong relationships with community-based organizations, local providers, as well as our state and federal partners. Our health plans develop tailored, local programs and campaigns to support members through solutions that promote whole-person care and enhance healthcare for all.
- *Data-driven approach to improve health outcomes.* We have employed an investment strategy designed to increase our capability to collect and analyze data and insights. We gather data from multiple sources including medical, vision and behavioral health claims and encounter data, pharmacy data, dental vendor claims and authorization data. We use this data to track utilization trends, identify health disparities, monitor quality of care and evaluate the effectiveness of our programs. Through these analyses, we identify and implement interventions that improve health outcomes, advance health equity and ensure members receive timely, appropriate services. The value and accuracy in the data we collect is important in demonstrating an auditable program for federal and state agencies.
- *Member programs and services.* Our comprehensive set of programs and services help members achieve whole-person health while supporting the overall goals of the government program. Covered healthcare benefits vary from customer to customer but cover a wide range of services, including transportation assistance, provision of durable medical equipment, behavioral health and substance use disorder services, 24-hour nurse advice line, social work services and telehealth services.
- *Value-based arrangements.* Our health plans offer a combination of value-based contracting models, including quality incentives and risk arrangements, that address the continuum of whole-person care. We believe value-based collaboration with providers leads to improved health outcomes, reduced costs and better member and provider experiences.

## Providers

For each of our service areas, we establish a provider network consisting of primary and specialty care physicians, hospitals, behavioral health practitioners and ancillary providers. Our network of primary care physicians is a critical component of care delivery, healthcare affordability, and the attraction and retention of new members. Primary care physicians include family and general practitioners, pediatricians and internal medicine physicians. Specialty care physicians provide medical care to members generally upon referral by primary care physicians. Specialty care physicians include a wide array of provider types including, but not limited to, orthopedic surgeons, cardiologists and otolaryngologists. We also build robust networks of mental health providers, such as psychiatrists, social workers, substance abuse disorder facilities, and inpatient behavioral health facilities. We also contract with providers on a negotiated fee arrangement for physical therapy, home healthcare, diagnostic laboratory tests, x-ray examinations, ambulance services and durable medical equipment.

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

- Under our fee-for-service contracts with providers, we pay a negotiated fee for covered services, which may include a case rate or fee-for service. This model is characterized as having no financial risk for the provider.
- Under our capitated contracts, providers can be paid a set amount for their services as outlined in their respective provider agreements, usually on a per member per month basis and sometimes including different rates depending on the age of the population.
- Under value-based arrangements, providers can be paid under either a capitated or fee-for-service model. The arrangement, however, contains provisions for additional payments to the providers or reimbursement from the providers based on their performance against quality and other measures. We are committed to value-based contracting, upside and downside risk, assigning members to the highest quality providers and capitation. This is done in partnership with our providers to increase quality outcomes and overall member satisfaction. We anticipate our membership in upside and downside risk arrangements will continue to grow.

The continuum of value-based contracting includes the following models: pay-for-performance, shared savings, shared risk and full risk. We often start our provider relationships in a pay-for-performance model, in which providers are reimbursed for the fair market value of services provided. Providers benefit from this model as it gives complete transparency and clarity on actions that earn incentives.

We then transition to a risk-sharing model, in which providers are reimbursed based on the total cost of care. As we advance along this continuum, it strengthens our partnerships with our providers, enabling the delivery of high-quality care. We believe having the strongest provider partners who know how to operate well in a value-based model and who can help us drive positive outcomes for our members and good member experience is more important than owning providers, which occurs on an exception basis. Prioritizing partnership over ownership allows us to be agile and capital-efficient, focusing our resources on what we do best.

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

We believe our local and collaborative approach with physicians and other providers gives us a competitive advantage in entering new markets. Our contracted physicians serve on local committees that assist us in implementing preventive care programs, optimizing costs and improving the overall quality of care delivered to our members, while also simplifying the administrative burdens on our providers. This approach has enabled us to strengthen our provider networks through improved physician recruitment and retention which, in turn, has helped to increase our membership base.

The following are among the services we provide to support physicians:

- *Provider Engagement Performance Tools and Processes* can lead to measurable improvements in quality and health outcomes, healthcare costs and member satisfaction. High-quality provider support and service levels are important as our key customers are increasingly using performance-based measures to select and pay health plans. We have a suite of network performance tools for use by physicians and other providers which monitor the outcomes and care gaps of their individual patient panels. Provider Engagement and Quality teams meet with the providers to review their performance issues and recommend strategies for improvements in their patient panel outcome, including disease management and quality initiatives. Our tools also allow the physician and others to see where they stand within their value-based contract.
- *Our Integrated Care Model* is member-centric and managed by one care manager assigned to a member who looks at the care for the member in a holistic manner. This single care manager will coordinate all care for that member including behavioral health, medical health and home-based primary care in accordance with an individualized, integrated care plan. This care manager also coordinates meetings with the member's integrated care team to assess and alter the care plan as needed. This results in better clinical outcomes and improved member satisfaction.
- *The Provider Portal* delivers claims and eligibility information, prior authorization submissions and status, member panels, care gaps, patient analytics and provider analytics to contracted providers to drive provider engagement and improve patient outcomes. Data and reporting are delivered via a secure, user-friendly web-based provider portal.

Our contracted physicians also benefit from several of the services offered to our members and population health management programs, which assist physicians in managing their patients with chronic diseases.

### **Quality Improvement**

Quality improvement is foundational for our organization. Our commitment to achieving better health outcomes for our members has led to recent investments in key initiatives involving people, processes, technology and partner management.

Through these initiatives, we have:

- centralized the oversight of core quality processes and programs, including the implementation of real-time operational dashboards to track numerous quality performance metrics;
- invested in new technology to enhance our access to clinical data on gaps in care, committed to integrating our numerous quality platforms into a single unified workflow and developed advanced analytics to more efficiently and effectively target our member engagement efforts for maximum impact on access, quality and member satisfaction;
- increased focus on member engagement, including tripling the capacity of our member outreach services to encourage active participation with their primary care physicians and other members of their care team and overhauling our onboarding process to focus on quality from the very first member touchpoint for Medicare; and
- prioritized strengthening relationships with providers to improve access and quality of care for our members; an essential strategy on this front is increasing our value-based provider engagements as those enhanced partnerships have proven to drive higher quality care. We also continue to promote local participation in physician quality improvement committees chaired by local physician leaders, which ensures clinical oversight and is critical to the success of clinical quality improvement programs.

We believe these initiatives will improve members' overall health and healthcare experience and help us achieve stronger quality scores overall, such as Medicare Star ratings and Marketplace QRS.

CMS developed the Medicare Advantage Five-Star Quality Rating System to help consumers choose among competing plans, awarding between 1.0 and 5.0 Stars to Medicare Advantage plans based on performance on composite measures of quality. The parent organization Star rating is used for new Medicare Advantage contracts while existing contracts follow their individual Star ratings to determine bonus payments.

Plans receive additional Medicare revenue related to the achievement of higher Star ratings that can be used to offer more attractive benefit packages to members and/or achieve higher profit margins. In addition, plans with Star ratings of 5.0 are eligible for year-round open enrollment, whereas plans with lower Star ratings have more restrictions on enrollment criteria and timing. Part C or Part D Medicare plans with Star ratings of fewer than three stars for three consecutive years are denoted as "low performing" plans on the CMS website and in the CMS "Medicare and You" handbook. In addition, CMS has the authority to terminate the Medicare Advantage and PDP contracts for plans rated below three Stars for three consecutive years for any Part (C or D). As a result, plans that achieve higher Star ratings may have a competitive advantage over plans with lower Star ratings.

As further validation of our quality objectives, we pursue accreditation by independent organizations that have been established to promote healthcare quality. NCQA Health Plan programs provide unbiased, third-party reviews to verify and publicly report results on specific quality metrics including Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS). We pursue and achieve accreditation in the majority of states where we currently have health plan operations. We also verify the credentials and backgrounds of our partner providers using standards supported by NCQA to ensure the quality of our networks.

Accreditation is only one measure of our ability to provide access to quality care for our members. The majority of state Medicaid programs also have specific quality measures that drive our clinical quality improvement efforts. Performance is monitored by health plan quality improvement committees and our corporate population health management and quality improvement teams.

We remain committed to our quality initiatives and continue to focus on investments that we expect to translate into value over the next few years.

## **ETHICS AND COMPLIANCE**

Our Ethics and Compliance program assists the organization in developing effective internal controls that promote the prevention, detection and correction of fraud, waste and abuse and instances of conduct that do not conform to federal and state law, private payor healthcare program requirements or our ethics and business policies. Responsibilities also include the ongoing maintenance of our privacy program and oversight of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as it pertains to us and our business units from a compliance, business and technical perspective.

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

These key components are:

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

The goal of our program is to build a culture of integrity, ethics and compliance, which is assessed periodically to measure engagement and effectiveness. Our Ethics and Compliance intranet site, accessible to all team members, links to our Code of Conduct and guidance for team members to assist them in reporting concerns or asking questions. Our Ethics and Compliance Helpline is a toll-free number and web-based reporting tool operated by a third-party independent of the Company and allows team members or other persons to anonymously report suspected incidents of misconduct, fraud, waste, abuse or other compliance violations, concerns or questions. Furthermore, our Board of Directors' Audit and Compliance Committee reviews ethics and compliance report data quarterly.

## CORPORATE SUSTAINABILITY

Our steadfast commitment to the health and social well-being of our communities, fostering a healthy environment and our culture of sound and ethical corporate governance, extends far beyond individual programs or initiatives. We provide access to high-quality healthcare, innovative programs and a wide range of health solutions that help people live healthier lives. Our mission is to transform the health of the communities we serve, one person at a time. Our Corporate Sustainability Framework (the Framework) is comprised of areas of focus core to our mission, our strategy and to delivering positive impact and long-term value to our stakeholders. The Framework highlights our commitment to healthy individuals and healthy communities and builds upon our long history of identifying and removing barriers to health. Implementation of the Framework is overseen by the Board of Directors' Governance Committee and corporate sustainability initiatives throughout the organization are driven by a cross-functional network of executives.

Annually, we issue a corporate sustainability report to communicate the value of our efforts, a Task Force on Climate-related Financial Disclosures (TCFD) Index report outlining our governance structure, strategy, risks, opportunities and metrics related to managing climate change, and a SASB Index report aligned with the SASB Managed Care standards maintained by the International Sustainability Standards Board providing corporate sustainability disclosures to our stakeholders. The Framework enables us to communicate impact and progress on corporate sustainability matters important to our stakeholders and aligned with our business strategy and long-term plans. Corporate sustainability financial reporting disclosures are overseen by the Board of Directors' Audit and Compliance Committee. Our corporate sustainability initiatives and commitments enable us to build healthier communities, empower health, foster a healthy environment and drive business accountability. Interested parties can find our corporate sustainability-related reports within the Investors section of our website, the URL of which is <https://investors.centene.com/sustainability>. *Please note: Nothing on our website, including our corporate sustainability reports or sections thereof, shall be deemed incorporated by reference into this Annual Report.*

## COMPETITION

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

We compete with other MCOs, specialty companies and other non-traditional competitors to acquire and retain state, county, federal and commercial contracts. Before granting a contract, state and federal government agencies consider many competitive factors, including but not limited to, quality of care, access to care through comprehensive provider networks, reducing administrative burden for providers and members, financial condition, stability and resources, previous experience and performance and local investments and offerings.

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

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

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

## REGULATION

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

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

Our regulated subsidiaries are licensed to operate as HMOs, preferred provider organizations (PPOs), third-party administrators (TPAs), utilization review organizations, pharmacies, direct care providers and/or insurance companies in their respective states. In each of the jurisdictions in which we operate, we are regulated by the relevant health and/or human services departments, Medicaid agencies, boards of pharmacy and other healthcare providers, departments of insurance, and departments of health that oversee the activities of MCOs and health plans providing or arranging to provide services to enrollees.

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

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

- premium taxes or similar assessments imposed on us;
- stringent prompt payment laws requiring us to pay claims within a specified period of time;
- mandated coverage of specific drugs or services;
- state-specific medical loss ratios that may be more stringent than federal requirements;
- disclosure requirements regarding provider fee schedules and coding procedures; and
- programs to monitor and supervise the activities and financial solvency of provider groups.

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

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

PPO laws and regulations also vary by state and cover all or most of the subject areas referred to above.

Our pharmacies must be licensed to do business as pharmacies in the states in which they are located. Our pharmacies must also register with the U.S. Drug Enforcement Administration and individual state-controlled substance authorities to dispense controlled substances.

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

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

The ACA transformed the U.S. healthcare system through a series of complex initiatives. Some of the ACA's most significant provisions include the imposition of fees, assessments and taxes; the establishment of federally-facilitated and state-based Health Insurance Marketplaces where individuals and small groups may purchase health coverage; the implementation of certain premium stabilization programs designed to apportion risk amongst insurers; and optional Medicaid Expansion. State and federal regulators have continued to provide additional guidance and specificity to the ACA, and we continue to monitor this new information and evaluate its potential impact on our business. For a further discussion of the ACA, see "***Risk Factors - Significant changes or judicial challenges to the ACA and the other government-sponsored healthcare programs in which we participate could materially and adversely affect our results of operations, financial condition, and cash flows.***"

We must also comply with laws and regulations related to the award, administration and performance of U.S. Government contracts. Government contract laws and regulations affect how we do business with our customers and, in some instances, impose added costs on our business. For example, money laundering is a method of attempting to conceal the origins of money gained through illegal activity and is itself a crime that can result in substantial criminal and civil sanctions including fines and imprisonment. To ensure compliance with anti-money laundering laws and regulations, it is our policy to conduct business only with legitimate customers and counterparties whose funds are derived from legitimate commercial activity. A violation of specific laws and regulations by us and/or our agents could result in, among other things, the imposition of fines and penalties on us, changes to our business practices, the termination of our contracts or debarment from bidding on contracts.

## State and Federal Businesses; Contracts

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

We provide Medicare Advantage, PDPs, D-SNPs and MMPs pursuant to contracts with CMS and subject to federal regulation regarding the award, administration and performance of such contracts. CMS also has the right to audit our performance to determine our compliance with these contracts, other CMS regulations, and the quality of care we provide to Medicare beneficiaries under these contracts.

As of December 31, 2024, we operated in 29 states under federally-facilitated Marketplace contracts with CMS and state-based exchanges. We also operate under a Memorandum of Understanding with the Arkansas Department of Human Services Division of Medical Services and the Arkansas Insurance Department to participate in the Medicaid expansion model that Arkansas has adopted (referred to as AR Health and Opportunity for Me program).

Our government contracts have included government-sponsored managed care and administrative services contracts through the TRICARE program and certain other healthcare-related government contracts. Our contract for health care delivery services through the TRICARE program concluded at the end of 2024.

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

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

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

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

Our federally-facilitated Marketplace contracts and state-based exchanges are renewable on an annual basis.

## **Other Fraud, Waste and Abuse Laws**

Investigating and prosecuting healthcare fraud, waste and abuse continues to be a top priority for state and federal law enforcement agencies. These efforts span multiple products, including Medicare, Medicaid, Health Insurance Marketplace and commercial plans. Pertinent fraud, waste and abuse laws include the federal False Claims Act, which prohibits the known filing of a false claim or the known use of false statements to obtain payment from the federal government. Many states have their own statutes that closely resemble the federal False Claims Act. A plan or provider may engage in other activities that violate fraud, waste and abuse laws, such as paying or receiving kickbacks or other inducements for the referral of members or coverage of products (such as prescription drugs), billing for unnecessary medical services or making false or misleading sales-related representations.

Our program integrity efforts aim to detect, prevent and correct fraud, waste and abuse. In addition to following up on leads from members, providers and our own team members, we use data analytics to identify suspicious activity and, as appropriate, will deny improperly billed claims, recover improperly made payments and make referrals to regulatory entities and law enforcement for further review. The laws and regulations relating to fraud, waste and abuse and the requirements applicable to health plans, PDPs and providers participating in these programs are complex and change regularly. Compliance with these laws may require substantial resources. We are constantly looking for ways to improve our fraud, waste and abuse detection methods. While we have both prospective and retrospective processes to identify abusive patterns and fraudulent billing, we continue to increase our capabilities to proactively detect inappropriate billing prior to payment.

## **Privacy Regulations**

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

HIPAA is designed to improve the portability and continuity of health insurance coverage, simplify the administration of health insurance through standard transactions and ensure the privacy and security of individual health information. Among the requirements of HIPAA are the Administrative Simplification provisions which include: standards for processing health insurance claims and related transactions (Transactions Standards); requirements for protecting the privacy and limiting the use and disclosure of medical records and other personal health information (Privacy Rule); and standards and specifications for safeguarding personal health information which is maintained, stored or transmitted in electronic format (Security Rule). The Health Information Technology for Economic and Clinical Health (HITECH) Act amended certain provisions of HIPAA and enhanced data security obligations for covered entities and their business associates. HITECH also mandated individual notifications in instances of a data breach, provided enhanced penalties for HIPAA violations and granted enforcement authority to states' Attorneys General in addition to the HHS Office for Civil Rights. The HIPAA Omnibus Rule further enhanced the changes under the HITECH Acts and the Genetic Information Nondiscrimination Act of 2008 which clarified that genetic information is protected under HIPAA and prohibits most health plans from using or disclosing genetic information for underwriting purposes. These regulations also establish significant criminal penalties and civil sanctions for non-compliance. The preemption provisions of HIPAA provide that the federal standards will not preempt state laws that are more stringent than the related federal requirements.

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

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

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

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

## **HUMAN CAPITAL RESOURCES**

As of December 31, 2024, we had approximately 60,500 team members. Our team members are guided by our mission-driven culture. Our culture values of accountability, courage, curiosity, trust and service guide our workforce and foster high-performing teams that serve our customers and key stakeholders each day while delivering against our long-term strategic goals. We intentionally attract, develop and retain top talent who bring a broad range of voices and experiences, passion and vision to help us transform the health of the communities we serve.

### **Compensation and Other Benefits**

Our overall compensation philosophy is to pay for performance by linking the achievement of both Company and individual goals to total compensation. We offer benefits to our team members to help them achieve optimum work-life balance and meet their needs as well as the needs of their families. In addition to traditional healthcare benefits, we also offer various wellness programs, an employee assistance program, tuition reimbursement/educational assistance, a 401(k) retirement plan, as well as programs for family support such as adoption assistance, parental leave and caregiver leave. Our parental leave offers six weeks of fully compensated time for caregivers with an additional eight weeks for mothers, providing up to 14 weeks of fully compensated maternity leave. In addition, we offer paid community volunteer time to encourage our team members to participate in volunteer programs and support local communities.

### **Talent Acquisition and Development**

Through our robust talent infrastructure, we continue working to deepen and prepare our talent bench and workforce, which is instrumental to executing our long-term business strategy. Our talent advisors and hiring leaders recruit from across the country to develop a workforce possessing outstanding capabilities and a wide range of perspectives and lived experiences. We are committed to developing a skill-rich workforce who can thrive in the evolving world of work, enabling our organization to further accelerate growth, inclusivity and innovation. Through Centene University, accessible to our team members, we have designed learning and development at scale, using new digital tools, real-time virtual learnings and customized leadership development programs in a modern learning environment. In addition to building new workforce skills, we utilize our ongoing enterprise talent reviews, succession planning, career development planning and comprehensive workforce analytics to provide insights to senior leaders to inform actions and drive intentional talent results.

### **Modernized and Connected Workforce**

We have adopted a modern work environment with the majority of our team members leveraging remote and hybrid work arrangements, allowing them to do their best work in the way they work best. We are intentional in our efforts to foster a collaborative and engaging work environment, including forums for people leaders, robust weekly communications for all team members, and virtual all-employee meetings. Additionally, we have a wide range of Centene Professional Networks. Open to all employees, these voluntary, employee-led groups provide professional connections and leadership opportunities for all team members and drive impact by supporting the attraction, development and retention of the best talent at all levels.

**INFORMATION ABOUT OUR EXECUTIVE OFFICERS**

The following table sets forth information regarding our executive officers, including their ages, at February 14, 2025:

<b>Name</b>	<b>Age</b>	<b>Position</b>
Sarah M. London	44	Chief Executive Officer
Andrew L. Asher	56	Executive Vice President, Chief Financial Officer
Katie N. Casso	43	Senior Vice President, Finance, Corporate Controller and Chief Accounting Officer
Christopher A. Koster	60	Executive Vice President, Secretary and General Counsel
Tanya M. McNally	51	Chief People Officer
Susan R. Smith	49	Chief Operating Officer

*Sarah M. London.* Ms. London has served as our Chief Executive Officer since March 2022. From September 2021 to March 2022, she served as Vice Chairman. She served as President, Centene Health Care Enterprises and Executive Vice President, Advanced Technology from March 2021 to September 2021. From September 2020 to February 2021, she served as Senior Vice President, Technology Innovation and Modernization. Prior to joining Centene, she served as both Senior Principal and Partner for Optum Ventures from May 2018 to March 2020 and Chief Product Officer of Optum from March 2016 to May 2018.

*Andrew L. Asher.* Mr. Asher has served as our Executive Vice President, Chief Financial Officer since May 2021. From January 2020 to May 2021, he served as Executive Vice President, Specialty. Prior to joining Centene, he served as the Chief Financial Officer of WellCare from November 2014 to January 2020.

*Katie N. Casso.* Ms. Casso has served as our Senior Vice President, Finance, Corporate Controller and Chief Accounting Officer since September 2024. Prior to that, she served as our Senior Vice President, Corporate Controller and Chief Accounting Officer from April 2021 to September 2024. From January 2016 to March 2021, she served as Vice President, Assistant Controller.

*Christopher A. Koster.* Mr. Koster has served as our Executive Vice President, Secretary and General Counsel since December 2021. From February 2020 to December 2021, he served as Senior Vice President, Secretary and General Counsel. From February 2017 to February 2020, he served as Senior Vice President, Corporate Services. Prior to joining Centene, Mr. Koster served as Missouri Attorney General for eight years.

*Tanya M. McNally.* Ms. McNally has served as our Chief People Officer since March 2023. Prior to that, she served as our Interim Chief People Officer from January 2023 to March 2023. Prior to that, she served as our Regional Vice President, Human Resources from May 2022 to December 2022. From January 2020 to May 2022, she served as Vice President, Global Human Resource Business Partner. From August 2018 to January 2020, she served as Vice President, Human Resources for WellCare Health Plans, Inc.

*Susan R. Smith.* Ms. Smith has served as our Chief Operating Officer since January 2024. Ms. Smith has been an employee of the Company since June 2023. From August 2022 through December 2022, she served as Senior Vice President of Clinical, Quality and Enterprise Solutions President at Humana Inc. From July 2021 through July 2022, she served as Senior Vice President of Clinical Solutions at Humana Inc. She also previously served as Senior Vice President of Medicare at Humana Inc. from August 2019 through June 2021. From October 2016 through July 2019, she served as Senior Vice President of Healthcare Quality Reporting and Improvement at Humana Inc.

**Available Information**

We are subject to the reporting and information requirements of the Securities Exchange Act of 1934, as amended (Exchange Act) and, as a result, we file periodic reports and other information with the Securities and Exchange Commission (SEC). We make these filings available on our website free of charge, the URL of which is <https://www.centene.com>, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. The SEC maintains a website (<https://www.sec.gov>) that contains our annual, quarterly and current reports and other information we file electronically with the SEC. Stockholders may obtain a copy of this Annual Report on Form 10-K, without charge, by writing: Investor Relations, Centene Corporation, 7700 Forsyth Boulevard, St. Louis, MO 63105. *Please note: Information on our website does not constitute part of this Annual Report on Form 10-K.*

## **Item 1A. Risk Factors.**

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

### **Risks Relating to Our Business**

***Failure to accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs could have a material adverse effect on our results of operations, financial condition and cash flows.***

Our profitability depends to a significant degree on our ability to accurately estimate and effectively manage expenses related to health benefits through, among other things, our ability to contract favorably with hospitals, physicians and other healthcare providers. For example, our government-sponsored health programs revenue is often based on bids submitted before the start of the initial contract year. If our actual medical expenses exceed our estimates, our health benefits ratio (HBR), or our expenses related to medical services as a percentage of premium revenues, would increase and our profits would decline. Because of the narrow margins of our health plan business, relatively small changes in our HBR can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of utilization of healthcare services, out-of-network utilization and pricing, medical claim submission patterns, hospital and pharmaceutical costs, including new high-cost specialty drugs, unexpected events, such as natural disasters, the effects of climate change, acts of war or aggression, geopolitical instability, major epidemics, pandemics and their resurgence, or newly emergent diseases, new medical technologies, increases in provider fraud and other external factors, including general economic conditions such as interest rates, inflation and unemployment levels, are generally beyond our control and could reduce our ability to accurately predict and effectively control the costs of providing health benefits. Also, member behavior could continue to be influenced by the uncertainty surrounding the ACA, including potential changes in premium subsidies, including due to changes in the eligibility or amount of enhanced advance premium tax credits for Marketplace products.

In addition, as a result of the expiration of the public health emergency (PHE) due to the COVID-19 pandemic, and the resulting Medicaid redeterminations process, we have experienced a higher HBR related to the remaining members, due to the acuity profile of this membership, as well as the gaps in eligibility for certain members who have rejoined the Medicaid plans. While we continue to work with our state partners to match rates to acuity post-redeterminations, such rate adjustments may be delayed or insufficient to offset the increased acuity.

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

Assumptions and estimates are utilized in establishing premium deficiency reserves. For example, we have established a premium deficiency reserve in connection with the 2025 Medicare Advantage business as of December 31, 2024. If our assumptions are inaccurate, we may be required to increase our premium deficiency reserves which could have a material adverse effect on our results of operations and financial condition.

Additionally, when we commence operations in a new state or region or launch a new product, we have limited information with which to estimate our medical claims liability. For a period of time after the inception of the new business, we base our estimates on government-provided historical actuarial data and limited actual incurred and received claims and inpatient acuity information. The addition of new categories of eligible individuals, as well as evolving Health Insurance Marketplace plans, may pose difficulty in estimating our medical claims liability.

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

***Any failure to adequately price or anticipate demand for products offered, anticipate changes to the competitive landscape or any reduction in products offered for Medicare Advantage and in the Health Insurance Marketplace may have a material adverse effect on our results of operations, financial condition and cash flows.***

In the Health Insurance Marketplace, we may be adversely impacted if we have not accurately predicted the health needs of our members, including individuals exiting the market causing the morbidity of the risk pool to rise without a proportionate change to risk adjustment. In addition, the risk adjustment provisions of the ACA established to apportion risk amongst insurers may not be effective in appropriately mitigating the financial risks related to the Health Insurance Marketplace product, are affected by our members' acuity relative to the membership acuity of other insurers and are subject to a high degree of estimation and variability, including estimation of the ultimate level of program funding based on the financial performance of other insurers. Further, changes in the competitive market for both Health Insurance Marketplace and the Medicare Advantage products over time, changes to member eligibility in the program design, including due to changes to the eligibility or amount of the enhanced advanced premium tax credits and the timing of those changes, additional program integrity initiatives that have the effect of reducing membership or changes in the financial incentives of individuals, brokers and competitors to participate in such products may make pricing difficult to predict. For example, competitors may introduce pricing, broker incentives or broker distribution channels that we may not be able to match, which may adversely affect our ability to compete effectively. Competitors may also choose to exit the market altogether or otherwise suffer financial difficulty, which could adversely impact the pool of potential insured, affect collectability of risk adjustment payable or require us to increase premium rates. Any significant variation from our expectations regarding acuity, enrollment levels, adverse selection, out-of-network costs or other assumptions utilized in setting adequate premium rates could have a material adverse effect on our results of operations, financial condition and cash flows for both our Health Insurance Marketplace and Medicare Advantage products.

In addition, we may be unable to accurately predict demand for both our Health Insurance Marketplace and Medicare Advantage products, as demand depends on factors outside of our control such as the competitiveness of our bids, the broker distribution channels, additional program integrity initiatives that have the effect of reducing membership and the entry and exit of other competitors in the markets. If we experience higher demand for our products than anticipated, we may not have adequate staffing to be able to adequately meet service level requirements in our call centers, which could negatively impact our quality scores, our relationships with our members and providers, as well as our regulators.

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

If we fail to design and maintain programs that are attractive to Medicare participants; if our Medicare operations are subject to negative outcomes from program audits, sanctions, penalties or other actions; if we do not submit adequate bids in our existing markets or any expansion markets; if our existing contracts are modified or terminated; or if we fail to maintain or improve our quality Star ratings, our current Medicare business and our ability to expand our Medicare operations could be materially and adversely affected, negatively impacting our results of operations and financial performance. As of December 2024, approximately 55% of our Medicare Advantage membership was associated with contracts rated 3.5 stars or better. Our quality improvement goal is to move 85% of our members into contracts with 3.5 stars or better for rating year 2026 (anticipated to be published in October 2025), which may not be achieved. Additionally, although we expect to have a higher percentage of D-SNP members than most of our competitors, we may be unsuccessful in advocating for adjustments in the Star score rating system or other risk adjustment criteria to reflect the socio-economic barriers to health for this population.

Star ratings are subject to change annually by CMS, and despite our operational efforts to improve our Star ratings, there can be no assurances that we will be successful in maintaining or improving our Star ratings in future years, which could negatively impact our quality bonus and rebates. In addition, our Medicare Advantage and PDP contracts may be terminated by CMS if our Medicare Advantage contracts receive Star ratings of below 3.0 stars for three consecutive years. For example, two of our Medicare Advantage contracts received notice of termination for plan year 2025. The attractiveness of our Medicare Advantage plans may be reduced if we are unable to maintain or improve these ratings, if there are changes to the ratings system that make achieving and maintaining ratings of 3.0 stars or higher more difficult, or if our performance does not improve compared to our competitors.

CMS establishes annually different pricing components of the Medicare Advantage program that may not adequately reflect changes in the underlying health care costs, and which may reduce the profitability or desirability of various Medicare Advantage plans. For calendar year 2025, CMS again applied a negative rate adjustment for risk model revisions and fee for service normalization. As a result of the Medicare Advantage 2025 rates and our 2025 Medicare Advantage bid design and membership projections, we have established a premium deficiency reserve in connection with the 2025 Medicare Advantage business as of December 31, 2024. In addition, CMS' new risk model may not account for the full severity of several chronic conditions, which could also disproportionately affect the dual-eligible population which is more medically complex and faces additional socio-economic barriers to health compared to others. As a result of these changes and potential future changes to Medicare Advantage pricing components, we may not be able to design products that will be profitable, attractive or competitive for this population.

In addition, CMS regulations will require beneficiaries dually enrolled in Medicare and in a Medicaid managed care plan to receive integrated care through the Medicaid company's Medicare Advantage D-SNPs beginning in 2030, with certain restrictions beginning in 2027, which may restrict our product offerings in some geographic service areas. However, some states have already moved or are planning to exclusively align dual-eligible enrollment under an aligned D-SNP before this timeframe.

There are also specific additional risks under Title XVIII, Part D of the Social Security Act associated with our provision of Medicare Part D prescription drug benefits as part of our Medicare Advantage plan offerings. These risks include potential uncollectibility of receivables, inadequacy of pricing assumptions, inability to receive and process information and increased pharmaceutical costs, as well as the underlying seasonality of this business, and extended settlement periods for claims submissions. Our failure to comply with Part D program requirements can result in financial and/or operational sanctions on our Part D products, as well as on our Medicare Advantage products that offer no prescription drug coverage.

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

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

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

Government customers have performed and continue to perform audits of selected plans to validate the provider coding practices under the risk adjustment model used to calculate the premium paid for each member. In 2023, CMS announced the removal of the fee-for-service adjuster from the risk adjustment data validation audit methodology beginning for audit year 2018, which could increase our audit error scores. We anticipate that CMS will continue to conduct audits of our Medicare contracts and contract years on an on-going basis. An audit may result in the refund of premiums to CMS. It is likely that a payment adjustment could occur as a result of these audits; and any such adjustment could have a material adverse effect on our results of operations, financial condition and cash flows.

***If we are not successful in procuring new government contracts or renewing existing government contracts, or if we receive an adverse finding or review resulting from an audit or investigation, our business may be adversely affected.***

A substantial portion of our business relates to the provision of managed care programs and selected services to individuals receiving benefits under governmental assistance or entitlement programs. We provide these and other healthcare services under contracts with government entities in the geographic areas in which we operate. Our government contracts are generally intended to run for a fixed number of years and may be extended for an additional specified number of years if the contracting entity or its agent elects to do so. Initial bids for these contracts and initial implementation of these contracts can have substantial start-up costs and may ultimately be unsuccessful. For example, prior to obtaining a certificate of authority in most jurisdictions, we must establish a provider network and have systems in place to administer a state contract and process claims. Once a new contract is awarded, we may experience delays in operational start dates. As a result of these factors, start-up operations may decrease our profitability, or we may not grow as quickly as we anticipated.

When our contracts with government entities expire, they may be opened for bidding by competing healthcare providers, and there is no guarantee that our contracts will be renewed or extended. For example, the Department of Defense did not award the West region TRICARE Managed Care Support Contract commencing in 2025 to Health Net Federal Services, and the contract ended as of December 31, 2024. In addition, as part of the normal course of business, several of our Medicaid contracts are up for reprocurement in 2025 (for contracts largely commencing in 2026). Competitors may be more aggressive in the descriptions of their capabilities and the assumptions utilized in their bids. Even if our responsive bids are successful, the bids may be based upon assumptions or other factors which could result in the contracts being less profitable than we had anticipated. Further, our government contracts contain certain provisions regarding readiness review, eligibility, enrollment and dis-enrollment processes for covered services, eligible providers, periodic financial and informational reporting, financial standards, quality assurance, timeliness of claims payment, compliance with contract terms and law and our agreement to maintain a Medicare plan in the state, among other things, and are subject to cancellation if we fail to perform in accordance with the standards set by regulatory agencies.

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

If any of our government contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, or if we receive an adverse finding or review resulting from an audit or investigation, our business and reputation may be adversely impacted, our goodwill could be impaired and our results of operations, financial condition or cash flows may be materially adversely affected.

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

***We derive a portion of our cash flow and gross margin from our PDP operations, for which we submit annual bids for participation. The results of our bids could have a material adverse effect on our results of operations, financial condition and cash flows.***

A significant portion of our PDP membership is obtained from the auto-assignment of beneficiaries in CMS-designated regions where our PDP premium bids are below benchmarks of other plans' bids. In general, our premium bids are based on assumptions regarding PDP membership, utilization, drug costs, drug rebates and other factors for each region. Our 2025 PDP bids resulted in 33 of the 34 CMS regions for which we were below the benchmarks and one region for which we were above the benchmark. As of January 1, 2025, we experienced an increase to over 7.5 million PDP members compared to 6.9 million in December 2024, due to our 2025 bid positioning. If our future Part D premium bids are not below the CMS benchmarks, we risk losing PDP members who were previously assigned to us and we may not have additional PDP members auto-assigned to us, which could materially reduce our revenue.

The IRA is expected to substantially increase PDP's risk exposure in 2025. Under the IRA, PDP plan costs will increase significantly due to a reduction in members cost share (close of coverage gap, and the \$2,000 cap on member out-of-pocket expenses) and a decrease in federal reinsurance (from 80% to 20%, while a greater portion of the plan drug costs will fall into the catastrophic phase). In the meantime, Part D risk sharing program thresholds would be applied to the increased Part D plan costs, so the plan cost at risk will be much greater before any risk sharing kicks in. These changes may lead to heightened underwriting risks and increased market volatility and uncertainty for 2025 bids, which could materially reduce our revenue and profit. The IRA also offers Part D enrollees the option to defer payment of out-of-pocket prescription drug costs across monthly payments throughout the benefit year instead of to the pharmacy at the point of sale under the Medicare Prescription Payment Plan (M3P). This change may lead to increased bad debt exposure along with potential challenges with collecting deductibles and other cost-sharing amounts from beneficiaries. The change may also lead to estimation uncertainty as we develop our experience with the M3P. Due to the uncertainty of the new Part D pricing structure, Centene has elected into the Part D Premium Stabilization Demonstration program, which subsidizes member premiums and provides additional protection through the risk corridor in the event of unforeseen losses, but such election may not be sufficient to offset the uncertainty or risks relating to our experience with M3P as well as the increased risk exposure.

***Our encounter data may be inaccurate or incomplete, which could have a material adverse effect on our results of operations, financial condition and 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 from our existing health plans and any health plans we may acquire in the future and have been and continue to be, exposed to operating sanctions and financial fines and penalties for noncompliance. In some instances, our government clients have established retroactive requirements for the encounter data we must submit. There also may be periods of time in which we are unable to meet existing requirements. In either case, it may be prohibitively expensive or impossible for us to collect or reconstruct this historical data.

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

***Increases in our pharmaceutical costs 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 cost 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 drugs without an appropriate rate adjustment or other reimbursement mechanism could have an adverse impact on our financial condition and results of operations. 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, changes in discounts, civil investigations and litigation. 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 be successful in that regard.

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

A number of our health plans rely on other state-operated systems or subcontractors to qualify, solicit, educate and assign eligible members into managed care plans. The effectiveness of these state operations and subcontractors can have a material effect on a health plan's enrollment in a particular month or over an extended period. When a state implements either new programs to determine eligibility or new processes to assign or enroll eligible members into health plans, or when it chooses new subcontractors, or has not adequately maintained systems, there is an increased potential for an unanticipated impact on the overall number of members assigned to managed care plans.

Additionally, we rely on the accuracy of eligibility lists provided by state governments and their vendors. 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 and their vendors. 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. 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. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Such factors could have an adverse effect on our premium revenues and results of operations, financial condition and cash flows.

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

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

***We derive a significant portion of our premium revenues from operations in a number of states, and our results of operations, financial condition or cash flows could be materially adversely affected by a decrease in premium revenues or profitability in any one of those states.***

Operations in a number of states have accounted for a significant portion of our premium revenues to date. If we were unable to continue to operate in any of those states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. For example, as part of the normal course of business, several of our Medicaid contracts are up for reprocurement in 2025 (for contracts largely commencing in 2026). Our reliance on operations in a limited number of states could cause our revenues and profitability to change suddenly and unexpectedly depending on legislative or other governmental or regulatory actions and decisions or changes in governmental administrations, economic conditions and similar factors in those states. Government entities in states we currently serve could open the bidding for their Medicaid or other healthcare programs to other health insurers through a request for proposal process. For example, as a result of Medicaid reprocurement process in California, in January 2024 our subsidiary, Health Net of California, began subcontracting a portion of its Medicaid membership in Los Angeles, which reduced our membership compared to December 2023. Reductions in our service area or services provided in any of the states in which we operate could harm our business.

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

We compete for members principally on the basis of size and quality of provider networks, the design and cost of benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state Medicaid programs that reimburse providers as care is provided, as well as other non-traditional competitors. In addition, the administration of the ACA has the potential to shift the competitive landscape in our segment.

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

***We operate in a highly competitive, dynamic and rapidly evolving industry and our failure to adapt could negatively impact our business.***

The health service industry continues to be competitive, dynamic and rapidly evolving. Any significant shifts in the structure of the industry could alter industry dynamics and adversely affect our ability to compete, attract or retain clients and customers. Industry shifts could result (and have resulted) from, among other things:

- a large intra- or inter-industry merger or industry consolidation;
- strategic alliances;
- change in broker distribution channels and requirements;
- continuing consolidation among physicians, hospitals and other health care providers, as well as changes in the organizational structures chosen by physicians, hospitals and health care providers;
- new market entrants, including those not traditionally in the health service industry; and
- innovations in technology in the health service industry, including the use of artificial intelligence and machine learning.

Our failure to anticipate or appropriately adapt to changes in the industry could negatively impact our competitive position and adversely affect our business and results of operations.

***If our third-party vendors fail to meet their contractual obligations to us or fail to comply with applicable laws or regulations, our results of operations may be adversely affected and we may be exposed to brand and reputational harm, litigation and/or regulatory action.***

We are subject to risks associated with outsourcing services and functions to third-party vendors. We contract with various third-party vendors to perform certain functions and services, including for PBM, medical management and other member-related services. Our arrangements with these third-party vendors may expose us to public scrutiny, adversely affect our brand and reputation, expose us to litigation or regulatory action, and otherwise make our operations vulnerable if we fail to adequately oversee, monitor and regulate their performance or if they fail to meet their contractual obligations to us, including successfully and timely transitioning services, delivering expected cost savings, guarantees or commitments, increasing their service levels to us, or complying with applicable laws or regulations.

Any failure of these third-party vendors' prevention, detection or control systems related to regulatory compliance, compliance with our internal policies, data security and/or cybersecurity or any incident involving the theft, misappropriation, loss or other unauthorized disclosure of, or access to, members' or other constituents' sensitive information could require us to expend significant resources to remediate any damage, interrupt our operations and adversely affect our brand and reputation and also expose us to whistleblower, class action and other litigation, other proceedings, prohibitions on marketing or active or passive enrollment of members, corrective actions, fines, sanctions and/or penalties, any of which could adversely affect our business results of operations, financial condition or cash flows. If the third-party vendors cannot adequately perform services to us due to lack of adequate staffing, infrastructure, experience, operational maturity, funding, bankruptcy, insolvency, or other credit failure, it could have a material adverse effect on our results of operations if we are not able to contract with other service providers on a timely basis or at all.

***If we are unable to maintain relationships with our provider networks and timely update our provider directories, our profitability may be materially adversely affected.***

Our profitability depends, in large part, upon our ability to contract at competitive prices with hospitals, physicians, and other healthcare providers. Our provider arrangements with our primary care physicians, specialists and hospitals generally may be canceled by either party without cause upon 90 to 120 days prior written notice. We cannot provide any assurance that we will be able to continue to renew our existing contracts or enter into new contracts on a timely basis or under favorable terms enabling us to service our members profitably. Healthcare providers with whom we contract may not properly manage the costs of, and access to services, be able to provide effective telehealth services, maintain financial solvency, pay secondary providers for services rendered (which could lead secondary providers to demand payment from us even though we have made our regular capitated payments to the provider group) or avoid disputes with other providers. Depending on state law and the regulatory environment, it may be necessary for us to pay such claims. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

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

From time to time, healthcare providers assert or threaten to assert claims seeking to terminate non-cancelable agreements due to alleged actions or inactions by us. If we are unable to retain our current provider contract terms or enter into new provider contracts timely or on favorable terms, our profitability may be materially adversely affected. In addition, from time to time, we may be subject to class action or other lawsuits by healthcare providers with respect to claim payment procedures or similar matters. For example, our wholly owned subsidiary, Health Net Life Insurance Company (HNL), is and may continue to be subject to such disputes with respect to HNL's payment levels in connection with the processing of out-of-network provider reimbursement claims for the provision of certain substance abuse related services. In the event HNL receives an adverse finding in any related legal proceeding or from a regulator or is otherwise required to reimburse providers for these claims at rates that are higher than expected or for claims HNL otherwise believes are unallowable, our financial condition and results of operations may be materially adversely affected. In addition, regardless of whether any such lawsuits brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management's attention. As a result, under such circumstances, we may incur significant expenses and may be unable to operate our business effectively.

In addition, we are subject to certain state and federal regulations and contractual provisions regarding provider directory accuracy. If we cannot comply with such accuracy requirements or other contractual operational requirements, we may be subject to regulatory audits and investigations, litigation and otherwise suffer competitive harm, which could have a material adverse impact on our business reputation, financial condition, cash flows or results of operations.

***If we or our third-party vendors are unable to integrate and manage information systems and networks effectively, our operations could be disrupted.***

Our operations depend significantly on effective information systems and networks. The information gathered and processed by information systems and networks assists us in, among other things, monitoring utilization and other cost factors, processing provider claims and providing data to our regulators. Our healthcare providers also depend upon our information systems and networks for membership verifications, claims status and other information. Our information systems, networks and applications require continual maintenance, upgrading and enhancement to meet our operational needs and regulatory requirements. We regularly upgrade and expand our information systems' and networks' capabilities. If we, our healthcare providers, brokers' or our third-party vendors experience difficulties with the transition to or from information systems or networks or do not appropriately integrate, maintain, enhance or expand information systems or networks, we could suffer, among other things, operational disruptions, loss of existing members and providers and difficulty in attracting new members and providers, complaints, regulatory problems and increases in administrative expenses. In addition, our healthcare providers', our brokers' or our third-party vendors' ability to integrate and manage information systems and networks may be impaired as the result of events outside our control, including natural disasters, such as earthquakes or fires, or acts of wars, aggression or terrorism, which may include cyber-attacks or other data security incidents by terrorists or other governmental or non-governmental actors. Further, as connectivity of technology advances, artificial intelligence and business processes supported by large language models that are used by us, our healthcare providers, our brokers, or our third-party vendors may not operate as expected or may give rise to risks related to accuracy, bias, discrimination, intellectual property infringement, cybersecurity and data privacy, among others. The development and use of artificial intelligence technologies is still in its early stages, and as a result it is not possible to predict all of the risks and potentially unintended consequences related to the use of artificial intelligence by us, our health care providers, our brokers or our third-party vendors.

We may also from time to time obtain significant portions of our systems-related or other services or facilities from independent third-party vendors, which may make our operations vulnerable if such third-party vendors fail to perform adequately. In addition, our ability to use outsourcing resources in certain jurisdictions might be limited by legislative action or contracts, with the result that the work must be performed at greater expense or we may be subject to sanctions for non-compliance. Any of these risks might have a materially adverse impact on our business, results of operations and financial condition.

***A failure in or breach of our operational or security systems, networks or infrastructure, or those of third-party vendors with which we do business, including as a result of cyber-attacks and other data security incidents, could have a material adverse effect on our business.***

Data security risks have significantly increased in recent years in part because of the proliferation of new technologies, the use of the internet and telecommunications technologies to conduct our operations and the increased sophistication and activities of organized crime, hackers, terrorists and other external parties, including foreign states and state-supported actors. Data security risks also may derive from fraud or malice on the part of our team members or third-party vendors, or may result from human error, software bugs, server malfunctions, software or hardware failure or other technological failure. As these threats continually evolve, we may be required to devote substantial additional resources to modify or enhance our operational or security systems and networks and our cybersecurity program.

Our operations rely on the secure transmission, storage and other processing of confidential, personal, proprietary, sensitive and other information in our computer systems and networks as well as third-party vendors with which we do business.

Security breaches of such systems and networks may arise from external or internal threats. External breaches may result from, among other things, a threat actor hacking personal information for financial gain, attempting to fraudulently induce our employees into disclosing usernames, passwords or other sensitive information to obtain unauthorized access to our systems, attempting to cause harm or interruption to our operations or intending to obtain competitive information. Internal breaches may result from, among other things, inappropriate security access to confidential information by rogue team members, consultants or third-party vendors. In addition, the rapid evolution and increased adoption of artificial intelligence technologies may intensify these risks by making such security breaches more difficult to detect, contain or mitigate. Any security breach could result in the misappropriation, loss or other unauthorized access, disclosure or use of confidential member information, including personal information, financial data, competitively sensitive information or other proprietary data, whether by us or a third party, and could have a material adverse effect on our business reputation, financial condition, cash flows or results of operations.

We maintain a system of prevention and detection controls through our security programs; however, our prevention and detection controls may not prevent or identify all such attacks on a timely basis, or at all. Despite our best attempts to maintain adherence to data privacy and security best practices, as well as compliance with applicable laws, regulations, rules, standards and contractual requirements, our facilities, systems and networks, and those of our third-party vendors, may be vulnerable to data privacy or security breaches, acts of vandalism or theft, malware, ransomware, social engineering attacks (including phishing attacks), denial-of-service attacks or other forms of cyber-attack, misplaced or lost data including paper or electronic media, programming and/or human errors or other similar events. We experience attempted external hacking or malicious attacks on a regular basis. In the past, we have experienced cyber-attacks and data breaches, and our third-party vendors have experienced cyber-attacks and security incidents, resulting in disclosure of confidential or protected health information that have not resulted in any material financial loss or penalty to date. For example, in 2024, Change Healthcare, Inc. experienced a cybersecurity incident that disrupted its ability to provide services, impacting payers, providers and pharmacies nationwide, including Centene and some of its subsidiaries. While this incident did not have a material impact on Centene, there can be no assurance that this incident and other privacy or security breaches will not require us to expend significant resources to remediate any damage, interrupt our operations and damage our business or reputation, subject us to state, federal, or international agency review, and result in enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, reputation, results of operations, financial condition and cash flows.

While we generally perform data security due diligence on our key service providers, we do not control our service providers and our ability to monitor their data security practices is limited. Some of our third-party vendors may store or have access to our data and may not have effective controls, processes, or practices to protect our information from loss, unauthorized disclosure, unauthorized use or misappropriation, cyber-attacks or other data security incidents. For example, hardware, software, and other applications and updates procured from service providers may contain defects that have and may in the future unexpectedly restrict or prevent access to or interfere with the proper operation of our information systems and hardware. A vulnerability in our service providers' hardware, software or systems, a failure of our service providers' safeguards, policies or procedures, or a cyber-attack or other data security incident affecting any of these third-party vendors could harm our business. Additionally, we cannot be certain that our insurance coverage will be adequate for data security liabilities actually incurred, that insurance will continue to be available to us on economically reasonable terms, or at all, or that our insurer will not deny coverage as to any future claim.

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

We are highly dependent on our ability to attract, develop and retain qualified personnel to operate and expand our business. We face intense competition for experienced and highly skilled team members, and we may be unable to attract and retain such team members, or competition among potential employers may result in increasing compensation. In addition, we may be adversely impacted if we are unable to adequately plan for the succession of our executives and senior management. While we have succession plans in place for members of our executive and senior management team, these plans do not guarantee that the services of our executive and senior management team will continue to be available to us. Our ability to replace any departed members of our executive and senior management team or other key team members may be difficult and may take an extended period of time because of the limited number of individuals in the Managed Care industry with the breadth of skills and experience required to successfully operate and expand a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel. Further, the availability of hybrid or remote working arrangements has expanded the pool of companies that can compete for our team members and employment candidates. Our modern work environment, including remote and hybrid work arrangements which is utilized by the majority of our team members, may present operational, cybersecurity and workplace culture challenges. If we are unable to attract, retain and effectively manage the succession plans for key personnel, executives and senior management, our business and financial condition, results of operations or cash flows could be harmed.

***An impairment charge with respect to our recorded goodwill, intangible assets and real estate portfolio could have a material impact on our results of operations and shareholders' equity.***

Changes in business strategy, divestitures, government regulations or economic or market conditions and non-renewal of government contracts have resulted and may result in impairments of our real estate portfolio, goodwill and other intangible assets at any time in the future. For additional information, see Note 6. *Property, Software and Equipment*, Note 7. *Goodwill and Intangible Assets*, and Note 11. *Leases* to the consolidated financial statements included in Part II of this Annual Report on Form 10-K. We may have additional impairment charges in connection with our periodic evaluation of our goodwill and intangible assets using assumptions and judgments regarding the estimated fair value of our reporting units. Our assumptions and judgments regarding the existence of impairment indicators are based on, among other things, legal factors, contract terms, market conditions and operational performance. Further, the estimated value of our reporting units may be impacted because of business decisions we make associated with any future changes to laws and regulations, which could unfavorably affect the carrying value of certain goodwill and other intangible assets and result in impairment charges in future periods. If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill and other intangible assets, such revision could result in a non-cash impairment charge that could have a material impact on our results of operations and shareholders' equity in the period in which the impairment occurs.

## **Risks Relating to Regulatory and Legal Matters**

***If eligibility for the enhanced advance premium tax credit for Marketplace members expires without renewal or the eligibility for the credit is modified or delayed, our results of operations, financial condition, and cash flows could be materially and adversely affected.***

In August 2022, the U.S. federal government enacted the Inflation Reduction Act, which, among other things, extended eligibility for the enhanced advance premium tax credit for Marketplace members. This enhanced credit expires on December 31, 2025, and if it is not renewed or extended, or if eligibility for this enhanced credit is limited, or if such renewal or extension is delayed, it could materially adversely impact our Marketplace membership. Submissions of the product design and pricing for the Marketplace product for the following calendar year is generally due to our state regulators in the summer. If the modifications or renewal of the credit is not known at that time, we may not be able to price our products appropriately or be able to change our product pricing or strategy in response to such modifications, which could materially adversely impact our Marketplace membership, financial condition and cash flows.

***Reductions or delays in funding, changes to eligibility requirements for government-sponsored healthcare programs in which we participate, and any inability on our part to effectively adapt to changes to these programs could have a material adverse effect on our results of operations, financial condition and cash flows.***

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, CHIP, LTSS, ABD, Foster Care and Health Insurance Marketplace premiums. Changes in these programs, including due to executive orders or other regulatory actions from the current political administration, could change the number of persons enrolled in or eligible for these programs, reduce funding, delay funding and increase our administrative and healthcare costs under these programs. For example, due to the declaration of the end of the PHE and the subsequent expiration of the eligibility determination waivers, the resumption of the Medicaid eligibility redeterminations significantly reduced our membership in our Medicaid programs, and we did not fully offset the loss of this membership by increased enrollment in our Health Insurance Marketplace products. In addition, as a result of the expiration of the PHE due to the COVID-19 pandemic, and the resulting Medicaid redeterminations process, we have experienced a higher HBR related to the remaining members, due to the acuity profile of this membership, as well as the gaps in eligibility for certain members who have rejoined the Medicaid plans. While we continue to work with our state partners to match rates to acuity post-redeterminations, such rate adjustments may be delayed or insufficient to offset the increased acuity. In addition, states may decide to reduce reimbursement or reduce benefits. If any state in which we operate were to decrease premiums paid to us or pay us less than the amount necessary to keep pace with our cost trends, it could have a material adverse effect on our results of operations, financial condition and cash flows.

Payments from government payors may be delayed in the future, which, if extended for any significant period of time, could have a material adverse effect on our results of operations, financial condition, cash flows or liquidity. In addition, delays in obtaining, or failure to obtain or maintain, governmental approvals, or moratoria imposed by regulatory authorities, could adversely affect our revenues or membership, increase costs or adversely affect our ability to bring new products to market as forecasted. Other changes to our government programs could affect our willingness or ability to participate in any of these programs or otherwise have a material adverse effect on our business, financial condition or results of operations.

Under most of these programs, the base premium rate paid for each program differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region and benefit mix. Since Medicaid was created in 1965, the federal government and states have shared the costs for this program, with the federal government share currently averaging approximately 60%. We are therefore exposed to risks associated with federal and state government contracting or participating in programs involving a government payor, including but not limited to the general ability of the federal and/or state governments to terminate or modify contracts with them, in whole or in part, without prior notice, for convenience or for default based on performance; potential regulatory or legislative action that may materially modify amounts owed; our dependence upon Congressional or legislative appropriation and allotment of funds and the impact that delays in government payments could have on our operating cash flow and liquidity; responses to pandemics, resurgences and new emergent diseases and other regulatory, legislative or judicial actions that may have an impact on the operations of government subsidized healthcare programs including ongoing litigation involving the ACA.

Future levels of funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints and spending initiatives or changes in political party or administrations at the state and federal level. Governments periodically consider reducing or reallocating the amount of money they spend for Medicaid, Medicare, CHIP, LTSS, ABD and Foster Care. Additionally, as a result of the CMS Medicare Advantage 2025 rate actions, combined with our quality scores, we have established a premium deficiency reserve in connection with the 2025 Medicare Advantage business as of December 31, 2024. Furthermore, Medicare remains subject to the automatic spending reductions imposed by the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 (sequestration), subject to a 2% cap, which was extended by the Bipartisan Budget Act of 2019 through 2029, which was reinstated on July 1, 2022, after a temporary suspension due to the COVID pandemic. Additional changes to the funding or eligibility criteria for these programs could materially impact our membership, revenues, financial condition and cash flows.

The IRA enacts significant changes to the Medicare Part D program beginning on January 1, 2025. These changes create additional uncertainty for 2025 Medicare Part D bids, including their profitability and the competitive market landscape. If our future Part D premium bids are not profitable or below the CMS benchmarks or competitors price their products with significantly lower premiums, membership, revenue and profitability of this product could be materially reduced, which in turn could have a material adverse effect on our results of operations and financial conditions. Further, changes in the Medicare Part D program could impact membership and cause the timing of our cash flows to be impacted, which in turn could impact the timing and level of interest income.

In addition, new CMS regulations will require beneficiaries dually enrolled in Medicare and Medicaid to receive integrated care through Medicare Advantage D-SNPs beginning in 2030, with restrictions beginning in 2027, which may restrict our product offerings in some geographic service areas.

In addition, adverse economic conditions may put pressures on state budgets as tax and other state revenues decrease while the population that is eligible to participate in these programs remains steady or increases, creating more need for funding. We anticipate this will require government agencies to find funding alternatives, which may result in reductions or delays in funding for programs, contraction of covered benefits and limited or no premium rate increases or premium rate decreases. A reduction (or less than expected increase), a protracted delay or a change in allocation methodology in government funding for these programs, as well as termination of one or more contracts for the convenience of the government, may materially and adversely affect our results of operations, financial condition and cash flows.

Also, if legislation increasing the federal debt ceiling is not enacted and the debt ceiling is reached, the federal government may stop or delay making payments on its obligations. In addition, if another federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicaid, Medicare, TRICARE, CHIP, LTSS, ABD, Foster Care and the Health Insurance Marketplace, may be delayed. Similarly, if state government shutdowns were to occur, state payment obligations may be delayed. If the federal or state governments fail to make payments under these programs on a timely basis, our business could suffer, and our financial condition, results of operations or cash flows may be materially affected.

***Significant changes or judicial challenges to the ACA and the other government-sponsored healthcare programs in which we participate could materially and adversely affect our results of operations, financial condition, and cash flows.***

The enactment of the ACA in March 2010 transformed the U.S. healthcare delivery system through a series of complex initiatives; however, the ACA has faced, and continues to face, administrative, judicial and legislative challenges to repeal or change certain of its significant provisions. Changes to portions or the entirety of the ACA or significant changes to the other government-sponsored healthcare programs in which we participate, as well as judicial interpretations in response to constitutional and other legal challenges, as well as the uncertainty generated by such actual or potential challenges, could materially and adversely affect our business and financial condition, results of operations or cash flows. The ultimate content, timing or effect of any potential future legislation or litigation and the outcome of other lawsuits cannot be predicted.

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

Additionally, the U.S. Department of Labor issued a final rule on June 19, 2018, which expanded flexibility regarding the regulation and formation of association health plans (AHPs) provided by small employer groups and associations. On June 13, 2019, the HHS, the U.S. Department of Labor and the U.S. Treasury issued a final rule allowing employers of all sizes that do not offer a group coverage plan to fund a new kind of health reimbursement arrangement (HRA), known as an individual coverage HRA (ICHRA). Beginning January 1, 2020, employees became able to use employer-funded ICHRAs to buy individual-market insurance, including insurance purchased on the public exchanges formed under the ACA. It remains uncertain whether or when the current or future administrations will propose changes to these insurance plan options that are not required to meet ACA requirements, and what the impact of such potential changes may be.

These changes and other potential changes involving the functioning of the Health Insurance Marketplace as a result of additional new state and federal legislation, regulation, executive action or litigation, including those related to extending enrollment periods, increasing eligibility in the program design, changing the eligibility and amount of the advanced premium tax credit, additional payment integrity initiatives that have the effect of reducing membership and expanding navigator services the timing of those changes and our ability to respond to any changes in compliance with our state and federal timing requirements, could impact our business and results of operations adversely or in other ways that we do not currently anticipate.

***Negative public perception of the managed care industry, including industry practices, could adversely affect our business, operating results, cash flows and prospects.***

The managed care industry in which we operate has been and may be negatively perceived by the public from time to time. This negative publicity can lead to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. Negative publicity could come as a result of adverse media coverage, including on social media, litigation against us or other industry participants, actual or perceived shortfalls regarding our industry's or our own products or services, and actual or perceived failures to meet customer or member expectations. Negative publicity resulting from any of these risks could adversely affect our business, our ability to attract and retain talent, our results of operations, stock price, brand, reputation, and our ability to retain our existing customers and members, and significantly change the regulatory and legislative requirements with which we must comply.

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

Our business is extensively regulated by the states in which we operate and by the federal government. Changes in political party, or administrations at the state or federal level may change the attitude or public commentary towards healthcare programs and result in changes to the existing legislative or regulatory environment, changes in the application of existing laws and regulations, or changes to funding available for healthcare programs. In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health, and/or human services or government departments that oversee the activities of MCOs providing or arranging to provide services to Medicaid, Medicare, Health Insurance Marketplace enrollees or other beneficiaries.

The frequent enactment of, changes to, or interpretations of laws and regulations could, among other things: force us to restructure our relationships with providers within our network; require us to implement additional or different programs and systems; restrict revenue and enrollment growth; increase our healthcare and administrative costs; impose additional capital and surplus requirements; modify how we contract, pay and interact with brokers, enact additional payment integrity initiatives that have the effect of reducing membership and increase or change our liability to members in the event of malpractice by our contracted providers. In 2023, HHS finalized transparency requirements for artificial intelligence and other predictive algorithms used in certified health information technology, such as decision support interventions. Changes to laws and regulations regarding how we may use artificial intelligence could make it harder for us to conduct our business using artificial intelligence; require us to retrain our artificial intelligence; or prevent or limit our use of artificial intelligence. Our use of artificial intelligence technologies could also result in additional compliance costs; regulatory investigations, actions, fines or penalties; and consumer or other lawsuits. To the extent that we rely on or use the output of artificial intelligence, any inaccuracies, biases or errors could have unfavorable impacts on us, our business and our results of operations or financial condition.

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

We are often required to maintain a minimum medical loss ratio (MLR) or share profits in excess of certain levels, which may be retroactive. In certain circumstances, our plans have returned premiums back to the states, enrollees or other beneficiaries in the event profits exceed established levels or MLR does not meet the minimum requirement. The amount of premium returned may include transparent pharmacy pricing and rebate initiatives. Other states may require us to meet certain performance and quality metrics in order to maintain our contracts or receive additional or full contractual revenue. In addition, our health plan subsidiaries must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements.

The governmental healthcare programs in which we participate are subject to the satisfaction of certain regulations and performance standards. Regulators require numerous steps for continued implementation of the ACA, including the promulgation of a substantial number of potentially more onerous federal regulations. If we fail to effectively or timely implement or appropriately adjust our operational and strategic initiatives with respect to the implementation of healthcare reform, or do not do so as effectively as our competitors, our results of operations may be materially adversely affected. For example, CMS regulations will require beneficiaries dually enrolled in Medicare and in a Medicaid managed care plan to receive integrated care through the Medicaid company's Medicare Advantage D-SNPs beginning in 2030, with certain restrictions beginning in 2027, which may restrict our product offerings in some geographic service areas. However, some states have already moved or are planning to exclusively align dual-eligible enrollment under an aligned D-SNP before this timeframe. Our inability to improve or maintain adequate quality scores and Star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs. Specifically, several of our Medicaid contracts require us to maintain a Medicare health plan.

In April 2016, CMS issued final regulations that revised existing Medicaid managed care rules by establishing a minimum MLR standard for Medicaid of 85% and strengthening provisions related to network adequacy and access to care, enrollment and disenrollment protections, beneficiary support information, continued service during beneficiary appeals, and delivery system and payment reform initiatives, among others. In May 2024, CMS issued further revisions to the Medicaid managed care regulations which become effective between July 2024 and July 2027. The 2024 Final Rule focused on changes in areas including access to care, delivery system and payment reform initiatives, MLR standards and quality oversight. Although we strive to comply with all existing regulations and to meet performance standards applicable to our business, failure to meet these requirements could result in financial fines and penalties. Also, states or other governmental entities may carve out certain services and benefits from the government programs in which we participate, or they may not allow us to continue to participate in their government programs or we may fail to win procurements to participate in such programs, any of which could materially and adversely affect our results of operations, financial condition and cash flows.

***Our ability to provide services and support to manage our members' pharmacy benefits face regulatory risks and uncertainties which could materially and adversely affect our results of operations, financial condition and cash flows.***

We provide services and support to manage our members' pharmacy benefits. These services are subject to extensive federal, state and local laws and regulations. In addition, federal and state legislatures and regulators regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including ownership of pharmacies by insurance companies, the receipt or disclosure of rebates from pharmaceutical companies, the development and use of formularies and the use of average wholesale prices.

Our specialty pharmacy business would be materially and adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers and other suppliers, though we use a network of specialty pharmacies beyond AcariaHealth. Disruptions at any of our specialty pharmacies due to an event that is beyond our control could affect our ability to process and dispense prescriptions in a timely manner and could materially and adversely affect our results of operations, financial condition and cash flows.

Contracts in the prescription drug industry generally use pricing metrics published by third parties as benchmarks to establish pricing for prescription drugs. If these benchmarks are no longer published by third parties, or we, or our contractual partners, adopt other pricing benchmarks for establishing prices within the industry, or legislation or regulation requires the use of other pricing benchmarks, or future changes in drug prices substantially deviate from our expectations, the short- or long-term impacts may have a material adverse effect on our business and results of operations.

***We have been and may from time to time become involved in costly and time-consuming litigation and other regulatory proceedings, which require significant attention from our management and could adversely affect our business.***

From time to time, we are a defendant in lawsuits and regulatory actions and are subject to investigations relating to our business, including, without limitation, medical malpractice claims; claims by members and providers alleging failure to timely and accurately pay for or provide healthcare; claims related to non-payment or insufficient payments for out-of-network services; claims related to provider directory accuracy, claims related to network adequacy; claims alleging bad faith; compliance with CMS Medicare and Marketplace regulations, including risk adjustment and broker compensation; claims related to the False Claims Act, the calculation of minimum MLR and rebates related thereto; claims related to privacy, intellectual property and vendor disputes; investigations regarding our submission of risk adjuster claims; putative securities class actions; protests and appeals related to Medicaid procurement awards; cybersecurity issues, including those related to our or our third-party vendors' information systems; employment-related disputes, including wage and hour claims; submissions to state agencies related to payments or state false claims acts, preauthorization penalties, timely review of grievance and appeals; and claims related to the imposition of new taxes, including but not limited to claims that may have retroactive application. Although we maintain some third-party insurance coverage, including excess liability insurance with third-party insurance carriers, certain liabilities or types of damages, such as punitive damages, may not be covered by insurance, insurers may dispute coverage or the amount of insurance may be insufficient to cover the entire damages awarded. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and time-consuming and require significant attention from our management and could therefore have a material adverse effect on our business and financial condition, results of operations or cash flows.

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

As part of our normal operations, we and our third-party vendors collect, retain and otherwise process confidential member information, including personal information. We and our third-party vendors are subject to various federal, state and international laws, regulations, rules, standards and contractual requirements regarding the use, disclosure and other processing of confidential member information (including personal information), including HIPAA, the HITECH Act, the Gramm-Leach-Bliley Act, which require us to protect the privacy of medical records and safeguard personal health information we maintain, use and otherwise process. Additionally, legislative and regulatory action at the federal, state and local levels is emerging in the areas of artificial intelligence and automation. These laws, rules and contractual requirements are subject to change and the regulatory environment surrounding data privacy and security laws is increasingly demanding. Compliance with existing or new data privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain or require us to alter our business model or operations. In some cases, such laws, rules, regulations and contractual requirements also apply to our third-party vendors and require us to obtain written assurances of their compliance with such requirements. Certain of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities.

From time to time, Congress also has considered, and may currently be considering, various proposals for other data privacy and security laws to which we may become subject if passed. We expect there will continue to be new proposed laws, regulations and industry standards concerning privacy, data protection, information security, and artificial intelligence and automation in the U.S. and other jurisdictions, and we cannot yet determine the impacts such future laws, regulations and standards may have on our businesses or the businesses of our customers.

At the U.S. state level, we may be subject to laws and regulations such as the California Consumer Privacy Act (as amended by the California Privacy Rights Act, collectively, the CCPA), which broadly defines personal information and gives California residents expanded privacy rights and protections, such as affording them the right to access and request deletion of their information and to opt out of certain sharing and sales of personal information. Numerous other states also have enacted, or are in the process of enacting or considering, comprehensive state-level data privacy and security laws and regulations that share similarities with the CCPA. Moreover, laws in all 50 U.S. states require businesses to provide notice under certain circumstances to consumers whose personal information has been disclosed as a result of a data breach.

Further, while we strive to publish and prominently display privacy policies that are accurate, comprehensive, and compliant with applicable laws, regulations, rules and industry standards, we cannot ensure that our privacy policies and other statements regarding our practices will be sufficient to protect us from claims, proceedings, liability or adverse publicity relating to data privacy and security. Although we endeavor to comply with our privacy policies and to obtain written assurances of our third-party vendors' compliance, we may at times fail to do so or be alleged to have failed to do so. The publication of our privacy policies and other documentation that provide promises and assurances about data privacy and security can subject us to potential government or legal action if they are found to be deceptive, unfair, or misrepresentative of our actual practices. Any concerns about our data privacy and security practices, even if unfounded, could damage our reputation and adversely affect our business.

We increasingly rely on new and evolving technologies, including those powered by or incorporating artificial intelligence, as part of our internal operations and in the delivery of our products and services. These new technologies could present ethical, technological, legal, regulatory and other risks. We are required by certain regulators to develop and implement policies and procedures to promote and sustain the responsible design, development, and use of artificial intelligence. Any inadequacy or failure in designing, implementing or complying with such policies and procedures, or failure in complying with emerging laws, regulations and standards governing artificial intelligence, could adversely affect our operations that use or rely on artificial intelligence, or could materially and adversely affect our business, reputation, results of operations, financial position and cash flows.

Any failure or perceived failure by us to comply with our privacy policies, or applicable data privacy and security laws, regulations, rules, standards or contractual obligations, or any compromise of security that results in unauthorized access to, or unauthorized loss, destruction, use, modification, acquisition, disclosure, release or transfer of personal information, may result in requirements to modify or cease certain operations or practices, the expenditure of substantial costs, time and other resources, proceedings or actions against us, legal liability, governmental investigations, enforcement actions, claims, fines, judgments, awards, penalties, sanctions and costly litigation (including class actions). Any of the foregoing could harm our reputation, distract our management and technical personnel, increase our costs of doing business, adversely affect the demand for our products and services, and ultimately result in the imposition of liability, any of which could have a material adverse effect on our business, financial condition and results of operations.

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

We, along with other companies involved in public healthcare programs, have been, and from time to time are, the subject of federal and state fraud, waste and abuse investigations. The regulations and contractual requirements applicable to participants in these public sector programs are complex and subject to change. Violations of fraud, waste and abuse laws applicable to us could result in civil monetary penalties, criminal fines and imprisonment and/or exclusion from participation in Medicaid, Medicare, and other federal healthcare programs and federally funded state health programs. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, incorrect and unsubstantiated billing or billing for unnecessary medical services, improper marketing and violations of patient privacy rights. These fraud, waste and abuse laws include the federal False Claims Act, which prohibits the known filing of a false claim or the known use of false statements to obtain payment from the federal government, and the federal anti-kickback statute, which prohibits the payment or receipt of remuneration to induce referrals or recommendations of healthcare items or services. Many states have fraud, waste and abuse laws, including false claim act and anti-kickback statutes that closely resemble the federal False Claims Act and the federal anti-kickback statute. In addition, the Deficit Reduction Act of 2005 encouraged states to enact state-versions of the federal False Claims Act that establish liability to the state for false and fraudulent Medicaid claims and that provide for, among other things, claims to be filed by *qui tam* relators (private parties acting on the government's behalf). Federal and state governments have made investigating and prosecuting healthcare fraud, waste and abuse a priority. In the event we fail to comply with the extensive federal and state fraud, waste and abuse laws, our business, reputation, results of operations, financial condition and cash flows could be materially and adversely affected.

At the federal level, HIPAA and the HITECH Act broadened the scope of fraud, waste and abuse laws under HIPAA applicable to healthcare companies and established enforcement mechanisms to combat fraud, waste and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of protected health information. The HITECH Act expanded the scope of these provisions by mandating individual notification in instances of breaches of protected health information, providing enhanced penalties for HIPAA violations, and granting enforcement authority to states' Attorneys General in addition to the HHS Office for Civil Rights. It is possible that Congress may enact additional legislation in the future to increase the amount or application of penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy and security provisions.

***We might be adversely impacted by tax legislation or challenges to our tax positions.***

We are subject to the tax laws in the U.S. at the federal, state and local government levels and to the tax laws of other jurisdictions in which we operate. Tax laws might change in ways that adversely affect our tax positions, effective tax rate and cash flow. We are subject to tax examinations in various jurisdictions that might assess additional tax liabilities against us. Our tax reporting positions might be challenged by relevant tax authorities, we might incur significant expense in our efforts to defend those challenges and we might be unsuccessful in those efforts. Developments in examinations and challenges might materially change our provision for taxes in the affected periods and might differ materially from our historical tax accruals. Any of these risks might have a material adverse impact on our business, results of operations, financial condition and cash flows.

#### **Risks Relating to Conditions in the Financial Markets and Economy**

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

We maintain a significant investment portfolio of cash equivalents and short-term and long-term investments in a variety of securities, which are subject to general credit, liquidity, market and interest rate risks and will decline in value if interest rates increase or one of the issuers' credit ratings is reduced. As a result, we may experience a reduction in value or loss of our investments, which may have an adverse effect on our results of operations, liquidity and financial condition. In addition, changes in the economic environment, including periods of increased volatility in the securities markets, and changes in interest rates, can increase the difficulty of assessing investment impairment and increase the risk of potential impairment of these assets. There is continuing risk that declines in the fair value of our investments may occur and material impairments may be charged to income in future periods, resulting in recognized losses.

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

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

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

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

As of December 31, 2024, we had consolidated indebtedness of \$18.5 billion. We may further increase or refinance our indebtedness in the future.

This may have the effect, among other things, of subjecting us to additional restrictive covenants and reducing our flexibility to respond to changing business and economic conditions and increasing borrowing costs.

Among other things, our Revolving Credit Facility and Term Loan Facility (collectively, the Company Credit Facility) and the indentures governing our notes require us to comply with various covenants that impose restrictions on our operations, including our ability to incur additional indebtedness, create liens, pay dividends, make certain investments or other restricted payments, sell or otherwise dispose of substantially all of our assets and engage in other activities. We are also exposed to interest rate risk to the extent of our variable rate indebtedness. Changes in interest rates can increase our cost of borrowing, and volatility in U.S. and global financial markets could impact our access to, or further increase the cost of, financing. Our Company Credit Facility also requires us to comply with a maximum debt-to-EBITDA ratio and a minimum fixed charge coverage ratio. These restrictive covenants could limit our ability to pursue our business strategies. In addition, any failure by us to comply with these restrictive covenants could result in an event of default under our Company Credit Facility and, in some circumstances, under the indentures governing our notes, which, in any case, could have a material adverse effect on our financial condition.

**Risks Associated with Mergers, Acquisitions, and Divestitures**

***Previous or future acquisitions may not perform as expected and we may not realize the financial results expected from acquisitions or divestitures.***

The market price of our common stock is generally subject to volatility, and there can be no assurances regarding the level or stability of our share price at any time. The market price of our common stock may decline as a result of previous or future acquisitions and divestitures if, among other things, we are unable to achieve the expected cost and revenue synergies or growth in earnings, the operational cost savings estimates are not realized as rapidly or to the extent anticipated, the transaction costs related to the acquisitions or divestitures are greater than expected or if any financing related to the transactions is on unfavorable terms. The market price of our common stock also may decline if we do not achieve the perceived benefits of such acquisitions and divestitures as rapidly or to the extent anticipated by financial or industry analysts or if the effect of the acquisitions and divestitures on our financial condition, results of operations or cash flows is not consistent with the expectations of financial or industry analysts.

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

We have acquired or may acquire in the future health plans participating in government-sponsored healthcare programs, contract rights and related assets of other health plans both in our existing service areas and in new markets and start-up operations in new markets or new products in existing markets. Although we review the records of companies or businesses we plan to acquire, it is possible that we could assume unanticipated liabilities or adverse operating conditions. In addition, the success of acquisitions we make will depend, in part, on our ability to successfully combine our existing business with such acquired businesses and realize the anticipated benefits, including synergies, cost savings, growth in earnings, innovation and operational efficiencies, from the combinations. In addition, we may be restricted in our ability to realize these synergies as a result of regulatory requirements. If we are unable to achieve these objectives within the anticipated time frame, or at all, the anticipated benefits may not be realized fully or at all or may take longer to realize than expected and the value of our common stock may decline.

The integration of acquired businesses with our existing business is a complex, costly and time-consuming process. The integration may result in material challenges, including, without limitation:

- the diversion of management's attention from ongoing business concerns and performance shortfalls as a result of the devotion of management's attention to the integration;
- managing a larger company;
- maintaining team member morale and retaining key management and other team members;
- the possibility of faulty assumptions underlying expectations regarding the integration process;
- retaining existing business and operational relationships and attracting new business and operational relationships;
- consolidating corporate and administrative infrastructures and eliminating duplicative operations;
- coordinating geographically separate organizations;
- unanticipated issues in integrating information technology, communications, and other systems;
- unanticipated changes in federal or state laws or regulations, including the ACA and any regulations enacted thereunder;
- unforeseen expenses or delays associated with the acquisition and/or integration, including due to regulatory approval requirements and delays;
- achieving actual cost savings at the anticipated levels; and
- decreases in premiums paid under government-sponsored healthcare programs by any state in which we operate.

Many of these factors would be outside of our control and any one of them could materially affect our financial condition, results of operations and cash flows. Our ability to successfully manage the expanded business following any given acquisition will depend, in part, upon management's ability to design and implement strategic initiatives that address the increased scale and scope of the combined business with its associated increased costs and complexity. There can be no assurances that we will be successful in managing our expanded operations as a result of acquisitions or that we will realize the expected growth in earnings, operating efficiencies, cost savings and other benefits.

***Our business and results of operations may be materially adversely affected if we fail to manage and complete divestitures.***

We regularly evaluate our portfolio to determine whether an asset or business is still consistent with our business strategy or whether there may be a more advantaged owner for that asset or business. When we decide to sell assets or a business, we may encounter difficulty finding buyers or alternative exit strategies, which could delay the achievement of our business strategy. Further, divestitures may be delayed due to failure to obtain required approvals on a timely basis, if at all, from governmental authorities, or may become more difficult to execute due to conditions placed upon approval that could, among other things, delay or prevent us from completing a transaction, or otherwise restrict our ability to realize the expected financial or strategic goals of a transaction. We might have financial exposure in a divested business, such as through minority equity ownership, financial or performance guarantees, indemnities or other obligations, such that conditions outside of our control might negate the expected benefits of the disposition. The impact of a divestiture on our results of operations could also be greater than anticipated.

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

None.

## **Item 1C. Cybersecurity**

### **Cybersecurity Risk Management and Strategy**

Our cybersecurity risk management and privacy programs play a central role in the protection of the confidential information of our members, team members, and business partners, and, as such, are critical to the successful operation of our business.

Our cybersecurity risk management program is part of our enterprise-wide risk management practices. Based on the National Institute of Standards and Technology (NIST) Cybersecurity Framework, the program utilizes policies, processes, and technologies to assess, identify, and manage the cybersecurity threats that we face. Specifically, we use these policies, processes and technologies to identify internal and external threats, establish access control, data privacy and security measures, detect unauthorized activity, and respond to and recover from incidents. For example, we leverage external experts and our internal threat and risk teams to assess potential threats, retain external consultants to conduct penetration tests and health checks on our information systems, conduct cyber security and awareness training to help team members identify and manage common categories of cybersecurity threats, utilize multiple protective and detective tools to identify active threats and have a 24/7 Security Operations Center to manage incident response.

Our cybersecurity risk management program also includes processes and controls to assess the cybersecurity risk associated with third-party vendors and partners. Following an initial assessment of the level of enterprise risk potentially posed by use of the third-party, the vendor is then subject to further risk-based assessments, the level of which depends upon the assigned risk value of the service being provided, which may include the completion of security questionnaires and the provision of independent security certifications.

On a bi-annual schedule, we use an external firm to assess our cybersecurity risk management program using the Capability Maturity Model Integration (CMMI) process and behavioral model. In addition, elements of the program are subject to Service Organization Control Type 2 (SOC 2) and ISO 27001 audits by a third party.

While we have not identified any cybersecurity threats that have materially affected or that we believe are reasonably likely to materially affect our business strategy, results of operations, or financial condition, our cybersecurity risk management program cannot eliminate all risks from cybersecurity threats or provide assurances that we have not experienced an undetected material cybersecurity incident or will not experience a material cybersecurity incident in the future. For more information about these risks, please see "*Risk Factors - A failure in or breach of our operational or security systems, networks or infrastructure, or those of third-party vendors with which we do business, including as a result of cyber-attacks and other data security incidents, could have a material adverse effect on our business.*"

### **Cybersecurity Risk Governance**

#### *Role of our Board of Directors*

Our Board of Directors has primary responsibility for the oversight of our enterprise-wide risk management and exercises its oversight function in respect of cybersecurity risk through two of its committees. Specifically, our Board Audit and Compliance Committee has oversight responsibility for the Company's enterprise risk management process, including the Company's programs to identify, manage, respond to and mitigate the Company's IT risks, including risks related to cybersecurity, artificial intelligence, privacy, critical infrastructure assets and disaster recovery, as well as identifying the potential likelihood, frequency and severity of cyberattacks and breaches. Our Board Quality Committee has oversight responsibility for overall data and technology strategy. Each committee reports to the full Board on a regular basis.

The oversight responsibility of our Board of Directors and its committees is facilitated through quarterly management-reporting processes designed to provide visibility to the Board and its committees on the processes for the identification, assessment, prioritization and management of critical risks and management's risk mitigation strategies. Such reporting includes providing regular updates to the Board Audit and Compliance Committee regarding the evolving cybersecurity threat environment, updates to our cybersecurity risk management program to address and mitigate such threats and providing quarterly reports to the Quality Committee on the Company's execution of its data and technology strategy. Management also escalates significant cybersecurity events to the Audit and Compliance Committee and the Board on a real time basis, as appropriate. Further, our Board also receives enterprise-wide risk management reports, which include significant cybersecurity risks, from our risk department multiple times per year. In addition, our Board and management have conducted tabletop cybersecurity crisis simulation exercises.

### *Role of Management*

While our Board of Directors has overall responsibility for the oversight of our enterprise-wide risk management, of which cybersecurity risk management is one component, our management team is responsible for day-to-day risk management, including the implementation of our cybersecurity risk management program.

Our enterprise risk management committee, which operates within our risk department and comprises certain of our senior leaders including operations, finance, information technology, government relations, legal, marketing, health plan leadership, health operations, and communications meets at least four times per year to discuss significant risks to the Company identified by our enterprise-wide risk management process, including cybersecurity risks identified by our cybersecurity risk management program. The enterprise risk management committee also discusses the steps management has taken to identify, monitor, assess, and control or avoid such exposures and reviews performance measures against the Company's risk appetite and tolerance and provides recommendations of corrective action where appropriate.

At an operational level, our Chief Security and Privacy Officer (CSPO) and our Chief Information Security Officer (CISO) lead the management of our cybersecurity risk management program.

Our CSPO is responsible for overseeing the day-to-day operation of our cybersecurity risk management program, including reporting systemic cybersecurity risk matters to our senior management and, as appropriate, to the Board of Directors. Our CISO oversees our cybersecurity operations, including all identity and access management functions, cybersecurity incident response operations and the effective operation of the suite of security tools we employ. The CISO and CSPO track key cybersecurity metrics across the enterprise, including metrics related to threat and vulnerability management, cybersecurity incidents and asset management and protection. Our CISO reports the status and efficacy of our cybersecurity operations to our senior management and, as appropriate, to the Board of Directors.

Using our cybersecurity incident response plan, each incident receives a severity rating using a scale approved by management. Based on that rating, we employ an escalation matrix that provides appropriate notifications to management, as well as to our Board of Directors.

The cybersecurity incident response plan is integrated into our overall crisis management plan and process, for which our CSPO has ultimate day-to-day responsibility. Our CSPO and CISO share joint responsibility for providing regular cybersecurity updates to our Audit and Compliance Committee, including updates on our key technology initiatives, including those involving cybersecurity, and their status.

Our CSPO, CISO and other dedicated cybersecurity risk management personnel are certified and experienced information systems security professionals and information security managers. Our CSPO has over 30 years of experience in information security having 16 years of experience leading information security programs and obtained the Certified Information Systems Security Professional certification from ISC2. Our CISO, who has over 34 years of experience in cyber operations, communications, crisis management and command and control, holds multiple graduate degrees, obtained the Certified Information Systems Security Professional certification from ISC2 and holds the Qualified Technical Expert certification from the Digital Director's Network.

**Item 2. Properties**

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

In connection with the adoption of a more modern, flexible work environment, we undertook a real estate optimization initiative in 2022 to evaluate future real estate needs and downsize our real estate footprint for owned and leased properties. As a result of this evaluation, we substantially changed the use of, or abandoned, various properties and recognized impairment charges for the years ended December 31, 2023 and 2022. No significant impairment charges were recognized related to the real estate optimization initiative in the year ended December 31, 2024.

We believe our current facilities are adequate to meet our operational needs for the foreseeable future.

**Item 3. Legal Proceedings**

A description of the legal proceedings to which we and our subsidiaries are a party is contained in Note 17. *Contingencies* to the consolidated financial statements included in Part II of this Annual Report on Form 10-K, and is incorporated herein by reference.

**Item 4. Mine Safety Disclosures**

Not applicable.

## PART II

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

#### Market for Common Stock

Our common stock has been traded and quoted on the New York Stock Exchange (NYSE) under the symbol "CNC" since October 16, 2003.

#### Stockholders

As of February 14, 2025, there were 980 holders of record of our common stock.

#### Issuer Purchases of Equity Securities

In November 2005, the Company's Board of Directors announced a stock repurchase program, which was most recently increased in December 2023. The Company is authorized to repurchase up to \$10.0 billion, inclusive of past authorizations, of which \$2.2 billion remains as of December 31, 2024.

The stock repurchase program is effected primarily through regular open-market purchases (which may include repurchase plans designed to comply with Rule 10b5-1 and accelerated share repurchases), the amounts and timing of which are subject to our discretion as part of our capital allocation strategy and may be based upon general market conditions and the prevailing price and trading volumes of our common stock. No duration has been placed on the repurchase program. We reserve the right to discontinue the repurchase program at any time.

The following table discloses purchases of our common stock for the quarter ended December 31, 2024.

#### Issuer Purchases of Equity Securities Fourth Quarter 2024 (Shares in thousands)

Execution Date	Total Number of Shares Purchased <sup>(1)</sup>	Average Price Paid per Share <sup>(2)</sup>	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (\$ in millions) <sup>(3)</sup>
October 1, 2024 - October 31, 2024	7,368	\$ 69.48	7,360	\$ 2,649
November 1, 2024 - November 30, 2024	7,060	59.61	7,032	2,230
December 1, 2024 - December 31, 2024	14	59.45	—	2,230
Total	14,442	\$ 64.64	14,392	\$ 2,230

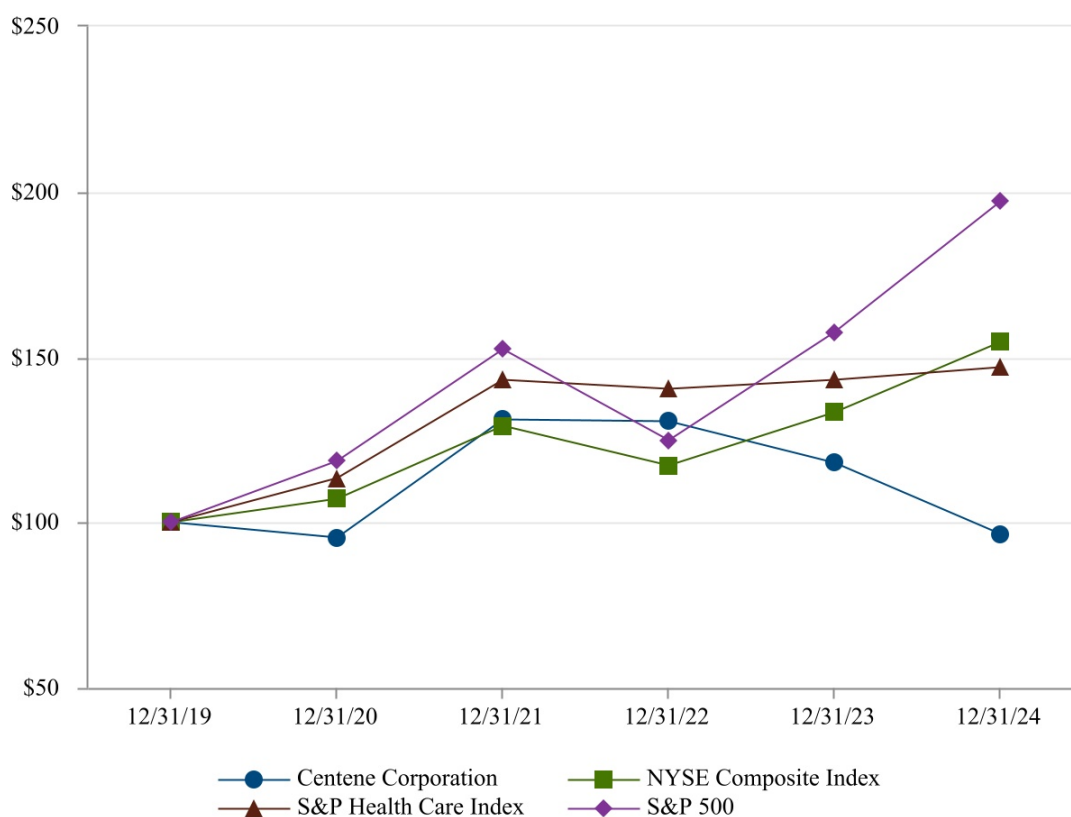
<sup>(1)</sup> Includes 29 thousand shares relinquished to the Company by certain employees for payment of taxes; an open market purchase of 4 thousand shares by Sarah London, the Company's CEO, at a weighted average price of \$60.80 which was previously disclosed on the Form 4 filed with the SEC on November 8, 2024; and an open market purchase of 17 thousand shares by Andrew Asher, the Company's CFO, at a weighted average price of \$58.14 which was previously disclosed on the Form 4 filed with the SEC on November 13, 2024.

<sup>(2)</sup> Average price paid per share excludes quarter-to-date accrued share repurchase excise tax of approximately \$10 million.

<sup>(3)</sup> A remaining amount of \$2.2 billion is available under the stock repurchase program as of December 31, 2024.

## Stock Performance Graph

The graph below compares the cumulative total stockholder return on our common stock for the period from December 31, 2019 to December 31, 2024, with the cumulative total return of the NYSE Composite Index, the Standard & Poor's (S&P) Health Care Index and the S&P 500 over the same period. S&P 500 is included because our common stock is within the index. The graph assumes an investment of \$100 on December 31, 2019 in our common stock (at the last reported sale price on such day), the NYSE Composite Index, the S&P Health Care Index and the S&P 500 and assumes the reinvestment of any dividends.



	2019	2020	2021	2022	2023	2024
Centene Corporation	\$ 100.00	\$ 95.48	\$ 131.06	\$ 130.44	\$ 118.04	\$ 96.36
NYSE Composite Index	100.00	106.99	129.11	117.04	133.20	154.36
S&P Health Care Index	100.00	113.45	143.09	140.29	143.18	146.87
S&P 500	100.00	118.40	152.39	124.79	157.60	196.99
Centene Corporation closing stock price	\$ 62.87	\$ 60.03	\$ 82.40	\$ 82.01	\$ 74.21	\$ 60.58
Centene Corporation annual stockholder return	9.1%	(4.5)%	37.3%	(0.5)%	(9.5)%	(18.4)%

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

**Item 6. *Reserved.***

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

*The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Part I, Item 1A. "Risk Factors" of this Form 10-K. The following discussion and analysis does not include certain items related to the year ended December 31, 2022, including year-to-year comparisons between the year ended December 31, 2023 and the year ended December 31, 2022. For a comparison of our results of operations for the fiscal years ended December 31, 2023 and December 31, 2022, see Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations of our Annual Report on Form 10-K for the year ended December 31, 2023, filed with the SEC on February 20, 2024.*

**EXECUTIVE OVERVIEW**

We are a leading healthcare enterprise that is committed to helping people live healthier lives. The Company takes a local approach – with local brands and local teams – to provide fully integrated, high-quality and cost-effective services to government-sponsored and commercial healthcare programs, focusing on under-insured and uninsured individuals. Centene offers affordable and high-quality products to more than 1 in 15 individuals across the nation, including Medicaid and Medicare members (including Medicare Prescription Drug Plans) as well as individuals and families served by the Health Insurance Marketplace.

We provide access to high-quality healthcare, innovative programs and a wide range of health solutions that help families and individuals get well, stay well and be well. Our uniquely local approach – with local brands and local teams who live in, care about and directly influence the communities they serve – is a key differentiator in our ability to provide access to quality care to our members. Centene treats the whole person, an approach that is delivered locally and backed by the scale of Centene's expertise, data and resources. Through this approach and our commitment to sustainable partnerships, we work with local community organizations to realize our mission of transforming the health of the communities we serve, one person at a time.

Our record of organic growth and strategic acquisitions have given us the size, scale and privilege of providing local high-quality and affordable health care to more than 28.6 million Americans. As of December 31, 2024, we were the largest Medicaid health insurer in the country, serving more than 13 million Medicaid recipients in 30 states. We were the largest Marketplace carrier, serving 4.4 million members across 29 states, served 1.1 million Medicare Advantage members across 37 states and were the largest stand-alone Medicare Prescription Drug Plan (PDP) provider serving 6.9 million members in 50 states and the District of Columbia. Consistent with our strategy, we have reduced our Medicare Advantage footprint to 32 states as of January 1, 2025.

**General**

Our results of operations depend on our ability to manage expenses associated with health benefits (including estimated costs incurred) and selling, general and administrative (SG&A) costs. We measure operating performance based upon two key ratios. The health benefits ratio (HBR) represents medical costs as a percentage of premium revenues, excluding premium tax revenues that are separately billed, and reflects the direct relationship between the premiums received and the medical services provided. The SG&A expense ratio represents SG&A costs as a percentage of premium and service revenues, excluding premium taxes separately billed.

**Divestitures**

In November 2022, we divested our ownership stakes in our Spanish and Central European businesses and as a result recorded an impairment charge of \$163 million, or \$140 million after-tax. During 2023, we recognized an additional loss on sale of \$13 million, or \$10 million after-tax.

In December 2022, we completed the divestiture of Magellan Rx for \$1.3 billion and recognized a gain of \$269 million, or \$99 million after-tax. During 2023, we recorded a reduction to the previously reported gain of \$22 million, or \$10 million after-tax, due to the finalization of working capital adjustments.

In January 2023, we sold Magellan Specialty Health for \$646 million in cash and stock, including an estimated working capital adjustment, and recognized a gain of \$79 million, or \$63 million after-tax. During 2024, we recorded an additional gain on sale of \$83 million for achievement of contingent consideration related to the sale and finalization of working capital adjustments.

In January 2023, we also completed the divestitures of Centurion and HealthSmart and recorded impairments of \$259 million (\$181 million after-tax) and \$36 million (\$27 million after-tax), respectively, in 2022. During 2023, we recognized a gain of \$15 million, or \$10 million after-tax, on the divestiture of the Centurion business reflecting additional proceeds for contingent consideration, partially offset by net working capital adjustments.

In June 2023, we completed the divestiture of our majority stake in Apixio and recognized a gain of \$93 million, or \$67 million after-tax.

In December 2023, we completed the divestiture of Operose Health Group (Operose Health) and recognized an impairment of \$140 million, or \$128 million after-tax.

In January 2024, we completed the divestiture of Circle Health Group (Circle Health) for \$931 million. Upon closing the divestiture, we settled the foreign currency swap associated with the divestiture and recorded a corresponding gain of \$20 million.

In October 2024, we completed the divestiture of Collaborative Health Systems (CHS) and recognized a pre-tax gain of \$17 million, or \$13 million after-tax.

The above-noted divestitures are drivers of certain year-over-year variances discussed throughout this section.

### **Regulatory Trends and Uncertainties**

The United States government, policymakers and healthcare experts continue to discuss and debate various elements of the United States healthcare model. We remain focused on the promise of delivering access to high-quality, affordable healthcare to all of our members and believe we are well positioned to meet the needs of the changing healthcare landscape.

The American Rescue Plan Act (ARPA), enacted in March 2021, initially enhanced eligibility for the premium tax credit for enrollees in the Health Insurance Marketplace. The enhanced eligibility extended by the Inflation Reduction Act (IRA), enacted in August 2022, expires at the end of 2025. We continue to advocate for legislation and regulations aimed at leveraging Medicaid and the Health Insurance Marketplace to maintain health insurance coverage and affordability for consumers.

The IRA significantly changes Medicare PDPs in 2025, most notably by eliminating the coverage gap and capping members' annual out-of-pocket cost at \$2,000 in order to provide more predictable and affordable prescription drug coverage for Medicare beneficiaries. The IRA changes effective for 2025 result in a meaningful shift in cost-sharing responsibilities between members, drug companies, CMS, and PDPs and will result in a significant increase in our premiums in consideration for our PDPs responsibility for a larger portion of total Part D benefit costs.

The COVID-19 pandemic impacted our business as it relates to Medicaid eligibility changes. From the onset of the public health emergency (PHE) through March 2023, our Medicaid membership increased by 3.6 million members (excluding new states North Carolina and Delaware and various state product expansions or managed care organization changes). Since March 31, 2023, redeterminations are the primary driver of our Medicaid membership decline. While some states may still be concluding the redetermination process for certain populations of members, we anticipate that any remaining reductions will be limited as the majority of states have substantially completed their unwinding processes as of December 2024. We continue to work with our state partners to match rates to acuity post-redeterminations.

In addition, newly finalized Centers for Medicare and Medicaid Services (CMS) regulations will require beneficiaries dually enrolled in Medicare and in a Medicaid Managed Care Plan to receive integrated care through the Medicaid company's Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) beginning in 2030, with certain restrictions beginning in 2027. However, some states have already moved or are planning to exclusively align dual-eligible enrollment under an aligned D-SNP before this timeframe. We believe we are positioned well given our overlapping Medicaid and Medicare Advantage footprints and are committed to navigating evolving regulations.

We also closely monitor state legislation across our markets and are advocating for and seeing adoption of coverage expansions for Medicaid populations (e.g., North Carolina), postpartum (now in effect for 48 states, the District of Columbia and the U.S. Virgin Islands), foster care children, among others, as well as mitigating adverse legislation addressing pharmacy, prior authorization and other issues. The Consolidated Appropriations Act, 2023 outlined key coverage expansion provisions, which went into effect in January 2024, requiring states to provide 12 months of continuous coverage for children under Medicaid and the Children's Health Insurance Program (CHIP).

We have four decades of experience, spanning seven presidents from both sides of the aisle, in delivering high-quality healthcare services on behalf of states and the federal government to under-insured and uninsured families, commercial organizations. This expertise has allowed us to deliver cost-effective services to our government partners and our members. With trends in the personalization of healthcare technology, we continue the use of data and analytics to improve the provider and member experience. We continue to believe we have both the capacity and capability to successfully navigate industry changes to the benefit of our members, customers, providers and shareholders.

For additional information regarding regulatory trends and uncertainties, see Part I, Item 1 "*Business - Regulation*" and Item 1A, "*Risk Factors*."

## **2024 Highlights**

Our financial performance for 2024 is summarized as follows:

- Year-end membership of 28.6 million, an increase of 1.1 million members, or 4% over 2023.
- Total revenues of \$163.1 billion, representing 6% growth year-over-year.
- Premium and service revenues of \$145.5 billion, representing 4% growth year-over-year.
- HBR of 88.3% for 2024, compared to 87.7% for 2023.
- SG&A expense ratio of 8.5% for 2024, compared to 9.0% for 2023.
- Adjusted SG&A expense ratio of 8.5% for 2024, compared to 8.9% for 2023.
- Diluted earnings per share (EPS) of \$6.31 for 2024, compared to \$4.95 for 2023.
- Adjusted diluted EPS of \$7.17 for 2024, compared to \$6.68 for 2023, representing 7% growth year-over-year.
- Operating cash flows of \$154 million for 2024, compared to \$8.1 billion for 2023.

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

We reference adjusted SG&A expense ratio defined as adjusted SG&A expenses, which excludes acquisition and divestiture related expenses and other items, divided by premium and service revenues. We also reference effective tax rate on adjusted earnings, defined as GAAP income tax expense (benefit) excluding the income tax effects of adjustments to net earnings divided by adjusted earnings (loss) before income tax expense.

	<b>Year Ended December 31,</b>	
	<b>2024</b>	<b>2023</b>
GAAP diluted EPS attributable to Centene	\$ 6.31	\$ 4.95
Amortization of acquired intangible assets	1.32	1.32
Acquisition and divestiture related expenses	0.16	0.13
Other adjustments <sup>(1)</sup>	(0.22)	0.85
Income tax effects of adjustments <sup>(2)</sup>	(0.40)	(0.57)
<b>Adjusted diluted EPS</b>	<b>\$ 7.17</b>	<b>\$ 6.68</b>

<sup>(1)</sup> Other adjustments include the following pre-tax items:

2024:

- (a) net gain on the previously reported divestiture of Magellan Specialty Health due to the achievement of contingent consideration and finalization of working capital adjustments of \$83 million, or \$0.16 per share (\$0.12 after-tax), net gain on the sale of property of \$24 million, or \$0.04 per share (\$0.03 after-tax), gain on the previously reported divestiture of Circle Health of \$20 million, or \$0.04 per share (\$0.12 after-tax), gain on the sale of CHS of \$17 million, or \$0.03 per share (\$0.02 after-tax), Health Net Federal Services asset impairment due to the 2024 final ruling on the TRICARE Managed Care Support Contract of \$14 million, or \$0.03 per share (\$0.02 after-tax), severance costs due to a restructuring of \$13 million, or \$0.02 per share (\$0.01 after-tax), an additional loss on the divestiture of our Spanish and Central European businesses of \$7 million, or \$0.01 per share (\$0.01 after-tax) and gain on the previously reported divestiture of HealthSmart due to the finalization of working capital adjustments of \$7 million, or \$0.01 per share (\$0.01 after-tax).

2023:

- (b) Circle Health impairment of \$292 million, or \$0.53 per share (\$0.47 after-tax), Operose Health impairment of \$140 million, or \$0.26 per share (\$0.24 after-tax), real estate impairments of \$105 million, or \$0.19 per share (\$0.16 after-tax), gain on the sale of Apixio of \$93 million, or \$0.17 per share (\$0.12 after-tax), severance costs due to a restructuring of \$79 million, or \$0.15 per share (\$0.11 after-tax), gain on the sale of Magellan Specialty Health of \$79 million, or \$0.14 per share (\$0.11 after-tax), a reduction to the previously reported gain on the sale of Magellan Rx of \$22 million, or \$0.04 per share (\$0.02 after-tax), gain on the previously reported divestiture of Centurion of \$15 million, or \$0.03 per share (\$0.02 after-tax) and an additional loss on the divestiture of our Spanish and Central European businesses of \$13 million, or \$0.02 per share (\$0.01 after-tax).

<sup>(2)</sup> The income tax effects of adjustments are based on the effective income tax rates applicable to each adjustment. In addition, the year ended December 31, 2024, includes a tax benefit of \$1 million, or \$0.00 per share, related to tax adjustments on previously reported divestitures. The year ended December 31, 2023 includes a one-time income tax benefit of \$69 million, or \$0.13 per share, resulting from the distribution of long-term stock awards to the estate of the Company's former CEO and tax expense of \$3 million, or \$0.01 per share, related to tax adjustments on previously reported divestitures.

## Current and Future Operating Drivers

The following items contributed to our 2024 results of operations as compared to the previous year:

### *Medicaid*

- In October 2024, our subsidiary, Meridian Health Plan of Michigan, commenced the contract awarded by the Michigan Department of Health and Human Services (MDHHS) to continue serving as a Medicaid health plan for the Comprehensive Health Care Program. The contract has a five-year term, with three optional one-year extensions, for a total of eight possible contract years.
- In September 2024, our subsidiary, Superior HealthPlan (Superior), commenced the contract awarded by the Texas Health and Human Services Commission to continue to provide healthcare coverage to the Aged, Blind or Disabled (ABD) population in the state's STAR+PLUS program. The contract has a six-year term with a maximum of three additional two-year extensions.
- In September 2024, our subsidiary, NH Healthy Families, commenced the contract awarded by the New Hampshire Department of Health and Human Services to continue providing physical health, behavioral health and pharmacy services for New Hampshire's Medicaid managed care program, known as Medicaid Care Management. The contract has a five-year term.
- In July 2024, our subsidiaries, Carolina Complete Health and WellCare of North Carolina, began coordinating physical and other health services with Local Management Entities/Managed Care Organizations under the state's new Tailored Plan program. The Tailored Plans are integrated health plans designed for individuals with significant behavioral health needs or intellectual/developmental disabilities.
- In June 2024, our subsidiary, Western Sky Community Care, concluded serving members upon the expiration of its New Mexico Medicaid managed care contract.
- In April 2024, our subsidiary, Oklahoma Complete Health, commenced the statewide contracts to provide managed care for the SoonerSelect and SoonerSelect Children's Specialty Plan programs. The new contracts have a one-year term with five, one-year renewal options.
- In January 2024, our subsidiary, Nebraska Total Care, commenced the statewide Medicaid managed care contract to continue serving the state's Medicaid Managed Care Program, known as Heritage Health. The initial contract term is five years and includes the option for two subsequent, one-year renewals, for a potential total of seven years.
- In January 2024, our California health plan commenced direct Medicaid contracts in 10 counties (Los Angeles, Sacramento, Amador, Calaveras, Inyo, Mono, San Joaquin, Stanislaus, Tulare and Tuolumne). In Los Angeles, a portion of the membership is subcontracted. Prior to January 2024, our California health plan previously served the state's Medicaid Managed Care population with contracts in 13 counties, including San Diego.
- In December 2023, our subsidiaries, Carolina Complete Health and WellCare of North Carolina, began providing coverage under North Carolina's new Medicaid Expansion program.
- In September 2023, our subsidiary, Superior, commenced a new six-year contract awarded by the Texas Health and Human Services Commission to continue providing youth in foster care with healthcare coverage through the STAR Health Medicaid program. Superior has been the sole provider of STAR Health coverage since the program launched in 2008.
- In April 2023, eligibility redeterminations related to the PHE began. States have substantially completed their unwinding processes as of December 2024. We continue to work with our state partners to match rates to acuity post-redeterminations.
- In April 2023, the state of New York removed pharmacy services for certain of our managed care contracts in connection with the state's transition of pharmacy services to Medicaid fee-for-service.
- In February 2023, our subsidiary, Buckeye Health Plan, commenced the Medicaid contract awarded by the Ohio Department of Medicaid to continue providing members with quality healthcare, coordinated services and benefits.

### *Medicare*

- Given our strong bid positioning, Medicare PDP membership increased 50% year-over-year.
- Consistent with our strategic positioning and bid strategy, Medicare Advantage membership declined 13% year-over-year.
- The decrease in our Star quality ratings in the 2023 rating year, which CMS published in October 2022, adversely impacted our 2024 Medicare revenue. The decrease in Star quality ratings was driven by the expiration of certain disaster relief provisions as well as deterioration in select metrics. As a result of this impact, we recorded a premium deficiency reserve of \$250 million in the fourth quarter of 2023. We anticipate that the 2025 Plan year will operate at a loss driven primarily by Star ratings; accordingly, we recorded a premium deficiency reserve of \$92 million in the fourth quarter of 2024.

### *Commercial*

- In 2024, our Health Insurance Marketplace product, Ambetter Health expanded into Delaware. In total, the Marketplace plan was available across 29 states. Additionally, Marketplace membership increased 12% year-over-year due to the expanded footprint, strong product positioning and open enrollment results, as well as overall market growth.

### *Other*

- In December 2024, Health Net Federal Services concluded serving members upon the expiration of its TRICARE Managed Care Support Contract.
- In October 2024, we completed the sale of CHS, a management services organization.
- In July 2024, our subsidiary, Magellan Health, commenced the Idaho Behavioral Health Plan contract.
- In December 2023 and January 2024, we completed the divestitures of Operose Health and Circle Health, respectively.
- In June 2023, we completed the divestiture of Apixio. We maintain a close relationship with, and a minority interest in, the business.
- In January 2023, we completed the divestitures of Magellan Specialty Health, Centurion and HealthSmart.

The benefits of successful execution of our value creation initiatives have impacted our current results of operations and will continue to impact future results of operations, including the implementation of our new third-party pharmacy benefits management (PBM) contract, which commenced in January 2024.

We expect the following items to impact our future results of operations, subject to the resolution of various third-party protests within the Medicaid segment:

### *Medicaid*

- In February 2025, our subsidiary, Sunshine Health, commenced the Statewide Medicaid Managed Care program, including integrated Managed Medical Assistance, Long-Term Care services, Serious Mental Illness, Child Welfare and HIV specialty products. The contract has a six-year term.
- In January 2025, our subsidiary, Sunflower Health Plan, commenced the contract to continue providing managed health care services through KanCare, the State of Kansas' Medicaid and Children's Health Insurance Program. The contract has a three-year term, with two optional one-year extensions, for a total of five possible contract years.
- In November 2024, our subsidiary, Buckeye Health Plan, was selected by the Ohio Department of Medicaid to continue providing Medicare and Medicaid services for dually eligible individuals through a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP). The three-year contract is expected to commence in January 2026.

- In September 2024, our subsidiary, Health Net Community Solutions, was selected by the California Department of Health Care Services to provide managed dental health care services to beneficiaries of Medi-Cal, the State's Medicaid program, in Los Angeles and Sacramento counties. The new 54-month contract is expected to commence in July 2025.
- In September 2024, our subsidiary, Iowa Total Care, was selected by the Iowa Department of Health and Human Services to continue providing Medicaid managed care services under the Iowa Health Link program. The contract is expected to begin in July 2025 and has a four-year term, with an optional two-year extension, for a total of six possible contract years.
- In August 2024, our subsidiary, PA Health and Wellness, was selected by the Pennsylvania Department of Human Services to continue to administer Pennsylvania's Community HealthChoices program, the Medicaid managed care program that covers adults who are dually eligible for Medicare and Medicaid or who qualify to receive Medicaid long-term services and supports due to a need for the level of care provided in a nursing facility. The contract is expected to begin in January 2026 and has a five-year term, with three optional one-year extensions, for a total of eight possible contract years.
- In December 2023, our subsidiary, Arizona Complete Health, was selected by the Arizona Health Care Cost Containment System – Arizona's single state Medicaid agency – to provide managed care for the Arizona Long Term Care System (ALTCS). The program supports Arizonans who are elderly and/or have a physical disability (E/PD) with physical and behavioral healthcare, as well as provides pharmacy benefits and home and community-based services. The new ALTCS-E/PD contract is expected to begin in October 2025 and has a three-year term, with four optional one-year extensions, for a total of seven possible contract years.
- In August 2022, our subsidiary, Magnolia Health Plan (Magnolia), was awarded the Mississippi Division of Medicaid contract. Under the new contract, Magnolia will continue serving the state's Coordinated Care Organization Program, which will consist of the Mississippi Coordinated Access Network and the Mississippi CHIP. The contract is expected to begin in July 2025 and has a four-year term, with two optional one-year extensions, for a total of six possible contract years.

### *Medicare*

- In 2025, Wellcare is offering Medicare Advantage plans in 32 states, including its newest state, Iowa. Wellcare discontinued offering Medicare Advantage products in Alabama, Massachusetts, New Hampshire, New Mexico, Rhode Island and Vermont in 2025.
- In October 2024, CMS issued 2025 Medicare Advantage Star Ratings on the Medicare Plan Finder. Based on the data as well as our successful appeal of the initial scoring of our TTY (Text-to-Voice teletypewriter services for the hearing impaired), we had approximately 55% of our Medicare Advantage membership enrolled in plans rated 3.5 stars or higher – compared to approximately 23% in the prior year. This represents meaningful progress despite higher than industry-anticipated cut point changes.
- In October 2024, our subsidiary, Meridian Health Plan of Michigan, was selected by the MDHHS to provide highly integrated Medicare and Medicaid services for dually eligible Michiganders through a Highly Integrated Dual Eligible Special Needs Plan. The plan is expected to launch on January 1, 2026 and has a seven-year term, with three optional one-year extensions, for a total of 10 possible contract years.

### *Commercial*

- In 2025, our Health Insurance Marketplace product, Ambetter Health, expanded its geographic footprint, adding 60 new counties across 10 states, which includes expansion into Iowa.

**MEMBERSHIP**

From December 31, 2023 to December 31, 2024, our managed care membership increased by 1.1 million, or 4%. The following table sets forth our membership by line of business:

	<b>December 31,</b>	
	<b>2024</b>	<b>2023</b>
Traditional Medicaid <sup>(1)</sup>	11,408,100	12,754,000
High Acuity Medicaid <sup>(2)</sup>	1,595,400	1,718,000
Total Medicaid	13,003,500	14,472,000
Commercial Marketplace	4,382,100	3,900,100
Commercial Group	431,400	427,500
Total Commercial	4,813,500	4,327,600
Medicare <sup>(3)</sup>	1,110,900	1,284,200
Medicare PDP	6,925,700	4,617,800
Total at-risk membership	25,853,600	24,701,600
TRICARE eligibles	2,747,000	2,773,200
Total	28,600,600	27,474,800

<sup>(1)</sup> Membership includes Temporary Assistance for Needy Families (TANF), Medicaid Expansion, Children's Health Insurance Program (CHIP), Foster Care and Behavioral Health.

<sup>(2)</sup> Membership includes Aged, Blind or Disabled (ABD), Intellectual and Developmental Disabilities (IDD), Long-Term Services and Supports (LTSS) and Medicare-Medicaid Plans (MMP) Duals.

<sup>(3)</sup> Membership includes Medicare Advantage and Medicare Supplement.

**RESULTS OF OPERATIONS**

The following discussion and analysis is based on our Consolidated Statements of Operations, which reflect our results of operations for years ended December 31, 2024 and 2023, respectively, prepared in accordance with generally accepted accounting principles in the United States (GAAP) (\$ in millions, except per share data in dollars):

	<b>2024</b>	<b>2023</b>	<b>% Change 2023-2024</b>
Premium	\$ 142,303	\$ 135,636	5 %
Service	3,202	4,459	(28)%
Premium and service revenues	145,505	140,095	4 %
Premium tax	17,566	13,904	26 %
Total revenues	163,071	153,999	6 %
Medical costs	125,707	118,894	6 %
Cost of services	2,729	3,564	(23)%
Selling, general and administrative expenses	12,400	12,563	(1)%
Depreciation expense	549	575	(5)%
Amortization of acquired intangible assets	692	718	(4)%
Premium tax expense	17,806	14,226	25 %
Impairment	13	529	(98)%
<b>Earnings from operations</b>	<b>3,175</b>	<b>2,930</b>	<b>8 %</b>
Investment and other income	1,784	1,393	28 %
Interest expense	(702)	(725)	(3)%
<b>Earnings before income tax expense</b>	<b>4,257</b>	<b>3,598</b>	<b>18 %</b>
Income tax expense	963	899	7 %
<b>Net earnings</b>	<b>3,294</b>	<b>2,699</b>	<b>22 %</b>
Loss attributable to noncontrolling interests	11	3	n.m.
<b>Net earnings attributable to Centene Corporation</b>	<b>\$ 3,305</b>	<b>\$ 2,702</b>	<b>22 %</b>
Diluted earnings per common share attributable to Centene Corporation	\$ 6.31	\$ 4.95	27 %

*n.m.: not meaningful*

**Year Ended December 31, 2024 Compared to Year Ended December 31, 2023**

**Total Revenues**

Total revenues increased 6% in the year ended December 31, 2024, over the corresponding period in 2023 primarily driven by membership growth in the Marketplace business due to strong product positioning as well as overall market growth and outperformance in Marketplace risk adjustment for the 2023 benefit year, along with Medicaid rate increases and increased premium tax revenue. The increases were partially offset by lower Medicaid membership primarily due to redeterminations and divestitures in the Other segment.

**Operating Expenses**

***Medical Costs/HBR***

The HBR for the year ended December 31, 2024 was 88.3%, compared to 87.7% in 2023. The increase was primarily driven by higher acuity in Medicaid resulting from the redetermination process as we continue to work with states to match rates with acuity. The increase was also driven by Medicare Star rating impacts. The increases were partially offset by Marketplace membership growth and improved margin through strong 2024 product design and execution, outperformance in Marketplace risk adjustment for the 2023 benefit year as well as the Marketplace cost sharing reduction (CSR) settlement related to prior years. The 2024 HBR was also favorably impacted by the decrease in the Medicare Advantage premium deficiency reserve-related expenses compared to 2023.

**Cost of Services**

Cost of services decreased by \$835 million in the year ended December 31, 2024, compared to the corresponding period in 2023. The cost of service ratio for the year ended December 31, 2024 was 85.2%, compared to 79.9% in 2023. The decrease in expense and increase in the ratio were primarily driven by the divestiture of Circle Health, which operated at a lower cost of service ratio.

**Selling, General & Administrative Expenses**

The SG&A expense ratio was 8.5% for the year ended December 31, 2024, compared to 9.0% for the year ended December 31, 2023. The adjusted SG&A expense ratio was 8.5% for the year ended December 31, 2024, compared to 8.9% for the year ended December 31, 2023. The decrease in the adjusted SG&A expense ratio was primarily driven by the divestiture of Circle Health, which operated at a higher SG&A expense ratio, lower Medicare SG&A, and continued leveraging of expenses over higher revenues. The decrease was partially offset by growth in the Marketplace business, which operates at a meaningfully higher SG&A expense ratio as compared to Medicaid.

**Impairment**

During the year ended December 31, 2024, we recorded total impairment charges of \$13 million driven by Health Net Federal Services property, software and equipment related to the TRICARE Managed Care Support Contract that was no longer recoverable following the 2024 final ruling.

During the year ended December 31, 2023, we recorded total impairment charges of \$529 million, including a \$292 million charge related to assets associated with the divestiture of Circle Health, a \$140 million charge related to the Operose Health divestiture and additional impairments of \$97 million related to our real estate optimization initiative.

**Other Income (Expense)**

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

	<u>2024</u>	<u>2023</u>
Investment and other income	\$ 1,784	\$ 1,393
Interest expense	<u>(702)</u>	<u>(725)</u>
Other income (expense), net	<u>\$ 1,082</u>	<u>\$ 668</u>

*Investment and other income.* Investment and other income increased by \$391 million for the year ended December 31, 2024 compared to 2023, driven by higher interest rates on larger investment balances. The year ended December 31, 2024 also included net gains on divestitures described above, partially offset by a private equity investment reduction. The year ended December 31, 2023 included net gains on divestitures described above, partially offset by a realized loss on the sale of investments from rebalancing a portion of our portfolio with a focus on higher interest rate investments.

*Interest expense.* Interest expense for the year ended December 31, 2024 was \$702 million compared to \$725 million for the corresponding period in 2023.

**Income Tax Expense**

For the year ended December 31, 2024, we recorded an income tax expense of \$963 million on pre-tax earnings of \$4.3 billion, or an effective tax rate of 22.6%. The effective tax rate for the year ended December 31, 2024 reflects tax effects of the Circle Health divestiture, which closed during the first quarter, settlements with tax authorities and valuation allowance releases. For the year ended December 31, 2024, our effective tax rate on adjusted earnings was 23.8%.

For the year ended December 31, 2023, we recorded income tax expense of \$899 million on pre-tax earnings of \$3.6 billion, or an effective tax rate of 25.0%. The effective tax rate for the year ended December 31, 2023 reflects the tax effects of the distribution of long-term stock awards to the estate of the Company's former CEO, divestiture gains and losses, lower state taxes as well as the then pending divestiture of Circle Health. For the year ended December 31, 2023, our effective tax rate on adjusted earnings was 24.9%.

## Segment Results

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

	2024	2023	% Change 2023-2024
<b>Total Revenues</b>			
Medicaid	\$ 101,417	\$ 100,759	1 %
Medicare	23,032	22,261	3 %
Commercial	33,702	24,845	36 %
Other	4,920	6,134	(20)%
Consolidated Total	<u>\$ 163,071</u>	<u>\$ 153,999</u>	<u>6 %</u>
<b>Gross Margin <sup>(1)</sup></b>			
Medicaid	\$ 6,246	\$ 8,641	(28)%
Medicare	2,595	2,867	(9)%
Commercial	7,663	5,029	52 %
Other	565	1,100	(49)%
Consolidated Total	<u>\$ 17,069</u>	<u>\$ 17,637</u>	<u>(3)%</u>

<sup>(1)</sup> Gross margin represents premium and service revenues less medical costs and cost of services.

### Medicaid

Total revenues increased 1% in the year ended December 31, 2024, compared to the corresponding period in 2023. Gross margin decreased \$2.4 billion in the year ended December 31, 2024, compared to the corresponding period in 2023. The increase in total revenues was primarily driven by increased premium tax revenue and rate increases, partially offset by lower membership primarily due to redeterminations. Gross margin decreased primarily due to lower overall membership as a result of the redetermination process, coupled with higher acuity post-redeterminations as we continue to work with our state partners to match rates to the changes in acuity.

### Medicare

Total revenues increased 3% in the year ended December 31, 2024, compared to the corresponding period in 2023, primarily driven by increased PDP membership of 50%, partially offset by lower Medicare Advantage membership. Gross margin decreased \$272 million in the year ended December 31, 2024, compared to the corresponding period in 2023 driven primarily by lower Medicare Advantage revenue resulting from the Star quality ratings impact and lower membership discussed above. Gross margin in 2024 was favorably impacted by the decrease in the Medicare Advantage premium deficiency reserve-related expenses compared to 2023 and growth and performance in the PDP business.

### Commercial

Total revenues increased 36% in the year ended December 31, 2024, compared to the corresponding period in 2023. Gross margin increased \$2.6 billion in the year ended December 31, 2024, compared to the corresponding period in 2023. The increases were primarily driven by 12% membership growth in the Marketplace business along with improved margin through strong 2024 product design and execution as well as outperformance in Marketplace risk adjustment for the 2023 benefit year and the Marketplace CSR settlement related to prior years.

### Other

Total revenues decreased 20% in the year ended December 31, 2024, compared to the corresponding period in 2023. Gross margin decreased \$535 million in the year ended December 31, 2024, compared to the corresponding period in 2023. The decreases were primarily due to divestitures.

**LIQUIDITY AND CAPITAL RESOURCES**

The following table is a condensed schedule of cash flows used in the discussion of liquidity and capital resources (\$ in millions):

	<b>Year Ended December 31,</b>	
	<b>2024</b>	<b>2023</b>
Net cash provided by operating activities	\$ 154	\$ 8,053
Net cash used in investing activities	(1,052)	(1,191)
Net cash used in financing activities	(2,406)	(1,658)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	8	(32)
Net increase (decrease) in cash, cash equivalents, and restricted cash and cash equivalents	<u>\$ (3,296)</u>	<u>\$ 5,172</u>

***Cash Flows Provided by Operating Activities***

Normal operations are funded primarily through operating cash flows and borrowings under our Revolving Credit Facility. In 2024, operating activities provided cash of \$154 million compared to providing cash of \$8.1 billion in 2023. Cash flows provided by operations in 2024 was primarily driven by net earnings, almost entirely offset by an increase in pharmacy receivables driven by pharmacy rebate remittance timing associated with our transition to a new third-party PBM in January 2024, a decrease in net risk adjustment payables and higher state premium receivables for recent rate increases.

Cash flows provided by operations in 2023 were primarily driven by net earnings, an increase in risk adjustment payable for Marketplace and the timing of pass-through payments.

***Cash Flows Used in Investing Activities***

Investing activities used cash of \$1.1 billion for the year ended December 31, 2024 and \$1.2 billion in 2023. Cash flows used in investing activities in 2024 and 2023 primarily consisted of net additions to the investment portfolio of our regulated subsidiaries (including transfers from cash and cash equivalents to long-term investments) and capital expenditures, partially offset by divestiture proceeds.

We spent \$644 million and \$799 million in the years ended December 31, 2024 and 2023, respectively, on capital expenditures primarily for system enhancements and computer hardware.

As of December 31, 2024, our investment portfolio consisted primarily of fixed-income securities with a weighted average duration of 3.4 years. We had unregulated cash and investments of \$1.1 billion at December 31, 2024. At December 31, 2023, we had unregulated cash and investments of \$1.0 billion, the majority of which was utilized in January 2024 to complete planned pass-through payments. Unregulated cash and investments include private equity investments and company owned life insurance contracts.

***Cash Flows Used in Financing Activities***

Financing activities used cash of \$2.4 billion in the year ended December 31, 2024, compared to using cash of \$1.7 billion in the comparable period in 2023. Financing activities in 2024 were driven by stock repurchases of \$3.1 billion, which included \$3.0 billion under the stock repurchase program and \$114 million of repurchases related to income tax withholding upon the vesting of previously awarded stock grants, partially offset by net proceeds from long-term debt.

In 2023, financing activities were driven by stock repurchases of \$1.6 billion.

## **Liquidity Metrics**

We have a stock repurchase program authorizing us to repurchase common stock from time to time on the open market or through privately negotiated transactions. In 2023, the Company's Board of Directors authorized up to a cumulative total of \$10.0 billion of repurchases under the program.

In 2024, we repurchased a total of 42.0 million shares of common stock for \$3.0 billion under the stock repurchase program, primarily funded through divestiture proceeds and free cash flow generated from operations. We have \$2.2 billion remaining under the program as of December 31, 2024. No duration has been placed on the repurchase program. We reserve the right to discontinue the repurchase program at any time. Refer to Note 12. *Stockholders' Equity* for further information on stock repurchases.

As of December 31, 2024, we had an aggregate principal amount of \$15.7 billion of senior notes issued and outstanding. The indentures governing our various maturities of senior notes contain limited restrictive covenants. As of December 31, 2024, we were in compliance with all covenants.

As part of our capital allocation strategy, we may decide to repurchase debt or raise capital through the issuance of debt in the form of senior notes. In 2022, the Company's Board of Directors authorized a \$1.0 billion senior note debt repurchase program. No repurchases were made during the year ended December 31, 2024. As of December 31, 2024, there was \$700 million available under the senior note debt repurchase program. Refer to Note 10. *Debt* for further information regarding the issuance and redemption of senior notes.

The credit agreement underlying our Revolving Credit Facility and Term Loan Facility contains customary covenants, as well as financial covenants, including, a minimum fixed charge coverage ratio and a maximum debt-to-EBITDA ratio. Our maximum debt-to-EBITDA ratio under the credit agreement may not exceed 4.0 to 1.0. As of December 31, 2024, we had \$950 million of borrowings outstanding under our Revolving Credit Facility, \$2.0 billion of borrowings outstanding under our Term Loan Facility and we were in compliance with all covenants. As of December 31, 2024, there were no limitations on the availability of our Revolving Credit Facility as a result of the debt-to-EBITDA ratio.

We had outstanding letters of credit of \$145 million as of December 31, 2024, which were not part of our Revolving Credit Facility. The letters of credit bore weighted interest of 0.7% as of December 31, 2024. In addition, we had outstanding surety bonds of \$844 million as of December 31, 2024.

At December 31, 2024, our debt-to-capital ratio, defined as total debt divided by the sum of total debt and total equity, was 41.2%, compared to 40.7% at December 31, 2023. The debt-to-capital ratio increase was driven by stock repurchases and increased borrowings under the Revolving Credit Facility in 2024 to fund pharmacy benefit-related activities, partially offset by net earnings. We utilize the debt-to-capital ratio as a measure, among others, of our leverage and financial flexibility.

At December 31, 2024, we had working capital, defined as current assets less current liabilities, of \$3.7 billion, compared to \$4.0 billion at December 31, 2023. We manage our short-term and long-term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid.

During the years ended December 31, 2024 and 2023, we received dividends of \$3.2 billion and \$2.3 billion, respectively, from our regulated subsidiaries.

## **2025 Expectations**

During 2025, we expect to receive net dividends of approximately \$1.9 billion from our regulated subsidiaries and expect to spend approximately \$700 million in capital expenditures primarily associated with system enhancements.

We have material short-term medical claims, debt and lease obligations. Refer to Note 8. *Medical Claims Liability*, Note 10. *Debt* and Note 11. *Leases*, respectively, for further information.

Based on our operating plan, we expect that our available cash, cash equivalents and short-term investments, cash from our operations and cash available under our Revolving Credit Facility will be sufficient to finance our general operations and capital expenditures for at least 12 months from the date of this filing. While we are currently in a strong liquidity position and believe we have adequate access to capital, we may elect to increase borrowings on our Revolving Credit Facility, which matures in August 2026. Additionally, our senior notes mature between December 2027 and August 2031. From time to time, we may elect to raise additional funds for working capital and other purposes, either through issuance of debt or equity, the sale of investment securities or otherwise, as appropriate. In addition, we may strategically pursue refinancing or redemption opportunities to extend maturities and/or improve terms of our indebtedness if we believe such opportunities are favorable to us.

We intend to continue to target initiatives to improve productivity, efficiencies and reduced organizational costs, as well as capital deployment activities, including stock repurchases, portfolio optimization and the evaluation of refinancing opportunities. In addition to creating shareholder value, these actions encompass a larger organizational mission to enhance our member and provider experience, improve outcomes for our members and innovate to ensure that Centene is a great partner in all aspects of our operations.

## REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

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

As of December 31, 2024, our subsidiaries had aggregate statutory capital and surplus of \$20.3 billion, compared with the required minimum aggregate statutory capital and surplus requirements of \$9.1 billion. During the year ended December 31, 2024, we received dividends of \$3.2 billion from and made \$752 million of capital contributions to our regulated subsidiaries. For our subsidiaries that file with the National Association of Insurance Commissioners (NAIC), we estimate our Risk Based Capital (RBC) percentage to be in excess of 350% of the Authorized Control Level.

Under the California Knox-Keene Health Care Service Plan Act of 1975, as amended (Knox-Keene), certain of our California subsidiaries must comply with tangible net equity (TNE) requirements. Under these Knox-Keene TNE requirements, actual net worth less unsecured receivables and intangible assets must be more than the greater of (i) a fixed minimum amount, (ii) a minimum amount based on premiums or (iii) a minimum amount based on healthcare expenditures, excluding capitated amounts.

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

The NAIC has adopted rules which set minimum risk-based capital requirements for insurance companies, MCOs and other entities bearing risk for healthcare coverage. As of December 31, 2024, each of our health plans was in compliance with the risk-based capital requirements enacted in those states.

As a result of the above requirements and other regulatory requirements, certain of our subsidiaries are subject to restrictions on their ability to make dividend payments, loans or other transfers of cash to their parent companies. Such restrictions, unless amended or waived or unless regulatory approval is granted, limit the use of any cash generated by these subsidiaries to pay our obligations. The maximum amount of dividends that can be paid by our insurance company subsidiaries without prior approval of the applicable state insurance departments is subject to restrictions relating to statutory surplus, statutory income and unassigned surplus. As of December 31, 2024, the amount of capital and surplus or net worth that was unavailable for the payment of dividends or return of capital to us was \$9.1 billion in the aggregate.

## RECENT ACCOUNTING PRONOUNCEMENTS

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

## CRITICAL ACCOUNTING ESTIMATES

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

### Goodwill and Intangible Assets

We have made several acquisitions that have resulted in our recording of intangible assets. These intangible assets primarily consist of purchased contract rights and customer relationships, provider contracts, trade names, developed technologies and goodwill. Key assumptions used in the valuation of these intangible assets include, but are not limited to, member attrition rates, contract renewal probabilities, revenue growth rates, expectations of profitability and discount and royalty rates. We allocate the fair value of purchase consideration to the assets acquired and liabilities assumed based on their fair values at the acquisition date. The excess of the fair value of consideration transferred over the fair value of the net assets acquired is recorded as goodwill. Goodwill is generally attributable to the value of the synergies between the combined companies and the value of the acquired assembled workforce, neither of which qualifies for recognition as an intangible asset. At December 31, 2024, we had \$17.6 billion of goodwill and \$5.4 billion of other intangible assets.

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

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

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

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

We operate in four segments: (1) a Medicaid segment, (2) a Medicare segment, (3) a Commercial segment and (4) an Other segment. We define our reporting units as our operating segments or one level below the operating segment. If a reporting unit's carrying amount exceeds its fair value, an entity will record an impairment charge based on that difference. The impairment charge will be limited to the amount of goodwill allocated to that reporting unit. We first assess qualitative factors to determine if a quantitative impairment test is necessary. We generally do not calculate the fair value of a reporting unit unless we determine, based on a qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount. However, in certain circumstances, such as recent acquisitions, we may elect to perform a quantitative assessment without first assessing qualitative factors.

We do not believe any of our reporting units are currently at risk for impairment.

## Medical Claims Liability

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

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

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

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

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

We review actual and anticipated experience compared to the assumptions used to establish medical costs. We establish premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with the method of acquiring, servicing and measuring the profitability of such contracts and expected investment income is excluded. We recorded a premium deficiency reserve of \$250 million in December 2023 related to the 2024 Medicare Advantage contract year. In December 2024, we recorded a premium deficiency reserve of \$92 million related to the 2025 Medicare Advantage contract year.

The paid and received completion factors, claims per member per month and per diem cost trend factors are the most significant factors affecting the IBNR estimate. The following table illustrates the sensitivity of these factors and the estimated potential impact on our operating results caused by changes in these factors based on December 31, 2024 data:

Completion Factors: <sup>(1)</sup>			Cost Trend Factors: <sup>(2)</sup>		
(Decrease) Increase in Factors	Increase (Decrease) in Medical Claims Liabilities		(Decrease) Increase in Factors	Increase (Decrease) in Medical Claims Liabilities	
	(In millions)			(In millions)	
(1.00)%	\$	1,221	(1.00)%	\$	(240)
(0.75)		912	(0.75)		(180)
(0.50)		605	(0.50)		(120)
(0.25)		301	(0.25)		(60)
0.25		(299)	0.25		60
0.50		(596)	0.50		120
0.75		(890)	0.75		180
1.00		(1,181)	1.00		240

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

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

While we believe our estimates are appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. For example, a 1% increase or decrease in our estimated medical claims liability would have affected net earnings by \$142 million for the year ended December 31, 2024, excluding the effect of any return of premium, risk corridor or minimum medical loss ratio (MLR) programs. The estimates are based on our historical experience, terms of existing contracts, our observation of trends in the industry, information provided by our providers and information available from other outside sources.

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

	Year Ended December 31,		
	2024	2023	2022
<b>Balance, January 1,</b>	\$ 18,000	\$ 16,745	\$ 14,243
Less: Reinsurance recoverables	49	26	23
Balance, January 1, net	17,951	16,719	14,220
Acquisitions and divestitures	—	—	105
Incurred related to:			
Current year	128,312	120,680	112,896
Prior years	(2,447)	(2,036)	(1,367)
Total incurred	125,865	118,644	111,529
Paid related to:			
Current year	111,456	104,725	97,799
Prior years	13,959	12,937	11,336
Total paid	125,415	117,662	109,135
Plus: Premium deficiency reserve	(158)	250	—
Balance, December 31, net	18,243	17,951	16,719
Plus: Reinsurance recoverables	65	49	26
<b>Balance, December 31,</b>	<b>\$ 18,308</b>	<b>\$ 18,000</b>	<b>\$ 16,745</b>
Days in claims payable <sup>(1)</sup>	53	54	54

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

Medical claims are usually paid within a few months of the member receiving service from the physician or other healthcare provider. As a result, the liability generally is described as having a "short-tail," which causes less than 10% of our medical claims liability as of the end of any given year to be outstanding the following year. We believe that the vast majority of the development of the estimate of medical claims liability as of December 31, 2024 will be known by the end of 2025.

Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. Additionally, as a result of minimum MLR and other return of premium programs, approximately \$243 million, \$382 million and \$198 million of the "Incurred related to: Prior years" was recorded as a reduction to premium revenues in 2024, 2023 and 2022, respectively. Further, claims processing and coordination of benefits initiatives yielded claim payment recoveries related to dates of service from prior years. Changes in medical utilization, claims submission patterns, and cost trends and the effect of population health management initiatives may also contribute to changes in medical claim liability estimates. While we have evidence that population health management initiatives are effective on a case by case basis, these initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the population health management initiative are not known by us. Additionally, certain population health management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the population health management initiative changed the behavior cannot be determined. Because of the complexity of our business, the number of states in which we operate and the volume of claims that we process, we are unable to practically quantify the impact of these initiatives on our changes in estimates of IBNR.

## **Revenue Recognition**

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

Our contracts with states and CMS may require us to maintain a minimum MLR or may require us to share cost-savings in excess of certain levels. In certain circumstances, including commercial plans, our plans may be required to return premium to the state or policyholders in the event costs are below established levels. We estimate the effect of these programs and recognize reductions in revenue in the current period. Other states may require us to meet certain performance and quality metrics in order to receive additional or full contractual revenue. For performance-based contracts, we do not recognize revenue subject to refund until data is sufficient to measure performance.

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

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

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

Our specialty companies generate revenues under contracts with state and federal programs, healthcare organizations and other commercial organizations and from our own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of services. For performance-based measures in our contracts, revenue is recognized as data sufficient to measure performance is available. We recognize revenue related to administrative services under the TRICARE government-sponsored Managed Care Support Contract for the Department of Defense (DoD's) TRICARE program on a straight-line basis over the option period, when the fees become fixed and determinable. The TRICARE contract includes various performance-based measures. For each of the measures, an estimate of the amount that has been earned is made at each interim date, and revenue is recognized accordingly. We concluded serving members at the end of 2024 upon the expiration of its TRICARE Managed Care Support Contract.

Some states enact premium taxes, similar assessments and provider pass-through payments, collectively premium taxes, and these taxes are recorded as a separate component of both revenues and operating expenses. For certain products, premium taxes and state assessments are not pass-through payments and are recorded as premium revenue and premium tax expense in the Consolidated Statements of Operations.

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

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

Market risk represents the risk of loss that may impact our financial condition due to adverse changes in financial market prices and rates. Our market risk exposure is primarily the result of fluctuations in interest rates.

**INVESTMENTS AND DEBT**

As of December 31, 2024, we had short-term investments of \$2.6 billion and long-term investments of \$18.8 billion, including restricted deposits of \$1.4 billion. The short-term investments generally consist of highly liquid securities with maturities between three and 12 months. The long-term investments consist of municipal, corporate and U.S. Treasury securities, government-sponsored obligations, life insurance contracts, asset backed securities, equity securities and private equity investments and have maturities greater than one year. Private equity investments include direct investments in private equity securities as well as private equity funds. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long-term regardless of the contractual maturity date. Substantially all of our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2024, the fair value of our fixed income investments would decrease by approximately \$665 million. Declines in interest rates over time will reduce our investment income.

For a discussion of the interest rate risk that our investments are subject to, see "Risk Factors - *Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity.*"

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

**Report of Independent Registered Public Accounting Firm**

To the Stockholders and Board of Directors  
Centene Corporation:

*Opinion on the Consolidated Financial Statements*

We have audited the accompanying consolidated balance sheets of Centene Corporation and subsidiaries (the Company) as of December 31, 2024 and 2023, the related consolidated statements of operations, comprehensive earnings (loss), stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2024, and the related notes (collectively, the consolidated financial statements). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2024 and 2023, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2024, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2024, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated February 18, 2025 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

*Basis for Opinion*

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

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

*Critical Audit Matters*

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

*Evaluation of the estimated medical claims liability*

As discussed in Note 2 to the consolidated financial statements, the Company's medical claims liability includes claims reported but not yet paid, estimates for claims incurred but not reported, and estimates for the costs necessary to process unpaid claims. As discussed in Note 8 to the consolidated financial statements, the balance at December 31, 2024 was \$18,308 million.

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

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

*Evaluation of the estimated Affordable Care Act risk adjustment accruals*

As discussed in Note 2 to the consolidated financial statements, the Affordable Care Act (ACA) established a permanent risk adjustment program. This program transfers funds from qualified individual and small group insurance plans with below average risk scores to those insurance plans with above average risk scores within each state. The final settlement of the December 31, 2024 ACA risk adjustment accruals is scheduled to be determined by the Centers for Medicare and Medicaid Services (CMS) in June 2025, based on data submitted by insurance companies through April 2025. As discussed in Note 9, the Company recorded an estimated asset and liability (the ACA risk adjustment accruals) of \$1,434 million, and \$1,605 million, respectively at December 31, 2024.

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

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

/s/ KPMG LLP

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

St. Louis, Missouri  
February 18, 2025

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

	<u>December 31, 2024</u>	<u>December 31, 2023</u>
<b>ASSETS</b>		
Current assets:		
Cash and cash equivalents	\$ 14,063	\$ 17,193
Premium and trade receivables	19,713	15,532
Short-term investments	2,622	2,459
Other current assets	1,601	5,572
Total current assets	37,999	40,756
Long-term investments	17,429	16,286
Restricted deposits	1,390	1,386
Property, software and equipment, net	2,067	2,019
Goodwill	17,558	17,558
Intangible assets, net	5,409	6,101
Other long-term assets	593	535
Total assets	<u>\$ 82,445</u>	<u>\$ 84,641</u>
<b>LIABILITIES, REDEEMABLE NONCONTROLLING INTERESTS AND STOCKHOLDERS' EQUITY</b>		
Current liabilities:		
Medical claims liability	\$ 18,308	\$ 18,000
Accounts payable and accrued expenses	13,174	16,420
Return of premium payable	2,008	1,462
Unearned revenue	661	715
Current portion of long-term debt	110	119
Total current liabilities	34,261	36,716
Long-term debt	18,423	17,710
Deferred tax liability	684	641
Other long-term liabilities	2,567	3,618
Total liabilities	55,935	58,685
Commitments and contingencies		
Redeemable noncontrolling interests	10	19
Stockholders' equity:		
Preferred stock, \$0.001 par value; authorized 10,000 shares; no shares issued or outstanding at December 31, 2024 and December 31, 2023	—	—
Common stock, \$0.001 par value; authorized 800,000 shares; 620,195 issued and 495,907 outstanding at December 31, 2024, and 615,291 issued and 534,484 outstanding at December 31, 2023	1	1
Additional paid-in capital	20,562	20,304
Accumulated other comprehensive (loss)	(504)	(652)
Retained earnings	15,348	12,043
Treasury stock, at cost (124,288 and 80,807 shares, respectively)	(8,997)	(5,856)
Total Centene stockholders' equity	26,410	25,840
Nonredeemable noncontrolling interest	90	97
Total stockholders' equity	26,500	25,937
Total liabilities, redeemable noncontrolling interests and stockholders' equity	<u>\$ 82,445</u>	<u>\$ 84,641</u>

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

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

	Year Ended December 31,		
	2024	2023	2022
<b>Revenues:</b>			
Premium	\$ 142,303	\$ 135,636	\$ 127,131
Service	3,202	4,459	8,348
Premium and service revenues	145,505	140,095	135,479
Premium tax	17,566	13,904	9,068
Total revenues	163,071	153,999	144,547
<b>Expenses:</b>			
Medical costs	125,707	118,894	111,529
Cost of services	2,729	3,564	7,032
Selling, general and administrative expenses	12,400	12,563	11,589
Depreciation expense	549	575	614
Amortization of acquired intangible assets	692	718	817
Premium tax expense	17,806	14,226	9,330
Impairment	13	529	2,318
Total operating expenses	159,896	151,069	143,229
<b>Earnings from operations</b>	<b>3,175</b>	<b>2,930</b>	<b>1,318</b>
<b>Other income (expense):</b>			
Investment and other income	1,784	1,393	1,279
Debt extinguishment	—	—	30
Interest expense	(702)	(725)	(665)
<b>Earnings before income tax</b>	<b>4,257</b>	<b>3,598</b>	<b>1,962</b>
Income tax expense	963	899	760
<b>Net earnings</b>	<b>3,294</b>	<b>2,699</b>	<b>1,202</b>
Loss attributable to noncontrolling interests	11	3	—
<b>Net earnings attributable to Centene Corporation</b>	<b>\$ 3,305</b>	<b>\$ 2,702</b>	<b>\$ 1,202</b>
<b>Net earnings per common share attributable to Centene Corporation:</b>			
Basic earnings per common share	\$ 6.33	\$ 4.97	\$ 2.09
Diluted earnings per common share	\$ 6.31	\$ 4.95	\$ 2.07
<b>Weighted average number of common shares outstanding:</b>			
Basic	521,790	543,319	575,191
Diluted	523,744	545,704	582,040

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

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

	<b>Year Ended December 31,</b>		
	<b>2024</b>	<b>2023</b>	<b>2022</b>
Net earnings	\$ 3,294	\$ 2,699	\$ 1,202
Change in unrealized gain (loss) on investments	94	520	(1,475)
Change in unrealized gain (loss) on investments, tax effect	(29)	(128)	349
Change in unrealized gain (loss) on investments, net of tax	65	392	(1,126)
Reclassification adjustment, net of tax	83	62	11
Foreign currency translation adjustments, net of tax	—	36	(94)
Net unrealized (loss) on cash flow hedge, net of tax	—	(10)	—
Other comprehensive earnings (loss)	148	480	(1,209)
Comprehensive earnings (loss)	3,442	3,179	(7)
Comprehensive loss attributable to noncontrolling interests	11	3	—
Comprehensive earnings (loss) attributable to Centene Corporation	<u>\$ 3,453</u>	<u>\$ 3,182</u>	<u>\$ (7)</u>

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

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

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock		Noncontrolling Interest	Total
	\$0.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Earnings (Loss)	Retained Earnings	\$0.001 Par Value Shares	Amt		
<b>Balance, December 31, 2021</b>	602,704	\$ 1	\$ 19,672	\$ 77	\$ 8,139	20,225	\$ (1,094)	\$ 145	\$ 26,940
Net earnings (loss)	—	—	—	—	1,202	—	—	(13)	1,189
Other comprehensive loss, net of \$(349) tax	—	—	—	(1,209)	—	—	—	—	(1,209)
Common stock issued for employee benefit plans	5,143	—	71	—	—	—	—	—	71
Fair value of unvested equity awards in connection with acquisition	—	—	60	—	—	—	—	—	60
Common stock repurchases	—	—	23	—	—	36,868	(3,119)	—	(3,096)
Stock compensation expense	—	—	234	—	—	—	—	—	234
Reclassification to non-redeemable	—	—	—	—	—	—	—	17	17
Divestiture of noncontrolling interest	—	—	—	—	—	—	—	(14)	(14)
Dividend to noncontrolling interest	—	—	—	—	—	—	—	(10)	(10)
Purchase of noncontrolling interest	—	—	—	—	—	—	—	(1)	(1)
<b>Balance, December 31, 2022</b>	607,847	\$ 1	\$ 20,060	\$ (1,132)	\$ 9,341	57,093	\$ (4,213)	\$ 124	\$ 24,181
Net earnings (loss)	—	—	—	—	2,702	—	—	(3)	2,699
Other comprehensive earnings, net of \$144 tax	—	—	—	480	—	—	—	—	480
Common stock issued for employee benefit plans	7,444	—	44	—	—	—	—	—	44
Common stock repurchases	—	—	—	—	—	23,714	(1,643)	—	(1,643)
Stock compensation expense	—	—	216	—	—	—	—	—	216
Purchase of redeemable noncontrolling interest	—	—	(12)	—	—	—	—	—	(12)
Purchase of non-redeemable noncontrolling interest	—	—	(4)	—	—	—	—	(24)	(28)
<b>Balance, December 31, 2023</b>	615,291	\$ 1	\$ 20,304	\$ (652)	\$ 12,043	80,807	\$ (5,856)	\$ 97	\$ 25,937
Net earnings (loss)	—	—	—	—	3,305	—	—	(5)	3,300
Other comprehensive earnings, net of \$31 tax	—	—	—	148	—	—	—	—	148
Common stock issued for employee benefit plans	4,904	—	46	—	—	—	—	—	46
Common stock repurchases	—	—	—	—	—	43,481	(3,141)	—	(3,141)
Stock compensation expense	—	—	212	—	—	—	—	—	212
Divestiture of noncontrolling interest	—	—	—	—	—	—	—	(2)	(2)
<b>Balance, December 31, 2024</b>	620,195	\$ 1	\$ 20,562	\$ (504)	\$ 15,348	124,288	\$ (8,997)	\$ 90	\$ 26,500

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

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

	<b>Year Ended December 31,</b>		
	<b>2024</b>	<b>2023</b>	<b>2022</b>
<b>Cash flows from operating activities:</b>			
Net earnings	\$ 3,294	\$ 2,699	\$ 1,202
Adjustments to reconcile net earnings to net cash provided by operating activities			
Depreciation and amortization	1,241	1,293	1,430
Stock compensation expense	212	216	234
Impairment	13	529	2,318
(Gain) loss on debt extinguishment	—	—	(25)
(Gain) on acquisition	—	—	(2)
Deferred income taxes	13	(78)	(631)
(Gain) loss on divestitures, net	(120)	(152)	(772)
Loss on disposal of equipment	—	—	221
Other adjustments, net	16	172	(31)
Changes in assets and liabilities			
Premium and trade receivables	(4,333)	(2,380)	(1,627)
Other assets	46	5	128
Medical claims liabilities	368	1,261	2,397
Unearned revenue	(54)	238	31
Accounts payable and accrued expenses	(528)	3,398	421
Other long-term liabilities	(70)	856	842
Other operating activities, net	56	(4)	125
Net cash provided by operating activities	<u>154</u>	<u>8,053</u>	<u>6,261</u>
<b>Cash flows from investing activities:</b>			
Capital expenditures	(644)	(799)	(1,004)
Purchases of investments	(7,183)	(6,622)	(6,736)
Sales and maturities of investments	5,785	5,523	3,802
Acquisitions, net of cash acquired	—	—	(1,460)
Divestiture proceeds, net of divested cash	990	707	2,477
Net cash used in investing activities	<u>(1,052)</u>	<u>(1,191)</u>	<u>(2,921)</u>
<b>Cash flows from financing activities:</b>			
Proceeds from long-term debt	1,300	2,335	360
Payments and repurchases of long-term debt	(622)	(2,316)	(1,490)
Common stock repurchases	(3,124)	(1,633)	(3,096)
Proceeds from common stock issuances	46	44	70
Payments for debt extinguishment	—	—	(14)
Purchase of noncontrolling interest	—	(88)	—
Other financing activities, net	(6)	—	(27)
Net cash used in financing activities	<u>(2,406)</u>	<u>(1,658)</u>	<u>(4,197)</u>
Effect of exchange rate changes on cash, cash equivalents and restricted cash	8	(32)	(11)
Net increase (decrease) in cash, cash equivalents and restricted cash and cash equivalents	<u>(3,296)</u>	<u>5,172</u>	<u>(868)</u>
Cash and cash equivalents reclassified (to) from held for sale	—	(50)	(16)
<b>Cash, cash equivalents and restricted cash and cash equivalents, beginning of period</b>	<u>17,452</u>	<u>12,330</u>	<u>13,214</u>
<b>Cash, cash equivalents and restricted cash and cash equivalents, end of period</b>	<u>\$ 14,156</u>	<u>\$ 17,452</u>	<u>\$ 12,330</u>
Supplemental disclosures of cash flow information:			
Interest paid	\$ 688	\$ 688	\$ 657
Income taxes paid, net	\$ 1,002	\$ 887	\$ 1,198
Equity issued in connection with acquisitions	\$ —	\$ —	\$ 60
The following table provides a reconciliation of cash, cash equivalents and restricted cash and cash equivalents reported within the Consolidated Balance Sheets to the totals above:			
	<b>2024</b>	<b>2023</b>	<b>2022</b>
Cash and cash equivalents	\$ 14,063	\$ 17,193	\$ 12,074
Restricted cash and cash equivalents, included in restricted deposits	93	259	256
Total cash, cash equivalents, and restricted cash and cash equivalents	<u>\$ 14,156</u>	<u>\$ 17,452</u>	<u>\$ 12,330</u>

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

**CENTENE CORPORATION AND SUBSIDIARIES**  
**NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS**

## **1. Organization and Operations**

Centene Corporation, or the Company, is a leading provider of government-sponsored healthcare. Centene's focus is on improving health and health care for low-income populations with complex needs. The Company provides access to high-quality healthcare, innovative programs and a wide range of health solutions that help families and individuals get well, stay well and be well.

The Company operates in four segments: (1) a Medicaid segment, (2) a Medicare segment, (3) a Commercial segment and (4) an Other segment. The Medicaid, Medicare and Commercial segments primarily represent the government-sponsored or subsidized programs under which the Company offers managed healthcare services. Specifically, the Medicaid segment includes the Temporary Assistance for Needy Families (TANF) program, Medicaid Expansion programs, the Aged, Blind or Disabled (ABD) program, the Children's Health Insurance Program (CHIP), Long-Term Services and Supports (LTSS), Foster Care, Medicare-Medicaid Plans (MMP), which cover beneficiaries who are dually eligible for Medicaid and Medicare and other state-based programs. The Medicare segment includes Medicare Advantage, Medicare Supplement, Dual Eligible Special Needs Plans (D-SNPs) and Medicare Prescription Drug Plans (PDPs), also known as Medicare Part D. The Commercial segment includes the Health Insurance Marketplace product along with individual, small group and large group commercial health insurance products. The Other segment includes the Company's pharmacy operations, Envolve Benefit Options' vision and dental services, clinical healthcare, behavioral health, international operations and corporate management company, among others. The Company's international businesses, Operose Health Group (Operose Health) and Circle Health Group (Circle Health), which were included in the Other segment, were divested in December 2023 and January 2024, respectively.

## **2. Summary of Significant Accounting Policies**

### ***Basis of Presentation***

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

Certain 2022 and 2023 amounts in the consolidated financial statements and notes to the consolidated financial statements have been reclassified to conform to the 2024 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

During 2024, the Company completed the divestitures of Circle Health and Collaborative Health Systems (CHS). See Note 3. *Acquisitions and Divestitures* for further details.

### ***Use of Estimates***

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

### ***Business Combinations***

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

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

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

### ***Cash and Cash Equivalents***

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

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

### ***Investments***

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

Short-term and long-term investments are generally classified as available-for-sale and are carried at fair value. Certain equity investments are recorded using the fair value or equity method. The Company monitors the difference between the carrying value and fair value of its available-for-sale debt investments and whether declines in fair value are credit related. Unrealized gains and losses on debt investments available-for-sale are excluded from earnings and reported in accumulated other comprehensive earnings (loss), a separate component of stockholders' equity, net of income tax effects. If a loss is deemed to be credit related, the Company recognizes an allowance through earnings. For each security in an unrealized loss position, the Company assesses whether it intends to sell the security or if it is more likely than not the Company will be required to sell the security before recovery of the amortized cost basis for reasons such as liquidity, contractual or regulatory purposes. If the security meets this criterion, the decline in fair value is recorded in earnings through investment and other income. Premiums and discounts are amortized or accreted over the life of the related security using the effective interest method. To calculate realized gains and losses on the sale of investments, the Company uses the specific amortized cost of each investment sold. Realized gains and losses are recorded in investment and other income.

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

### ***Restricted Deposits***

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

### ***Fair Value Measurements***

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

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

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

### ***Property, Software and Equipment***

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

<u>Fixed Asset</u>	<u>Depreciation Period</u>
Buildings and improvements	10 - 40 years
Computer hardware and software	3 - 5 years
Furniture and equipment	5 - 10 years
Land improvements	10 - 25 years
Leasehold improvements	1 - 20 years

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

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

### ***Goodwill and Intangible Assets***

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

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

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

The Company operates in four segments: (1) a Medicaid segment, (2) a Medicare segment, (3) a Commercial segment and (4) an Other segment. The Company defines its reporting units as its operating segments or one level below the operating segment. The Company tests goodwill for impairment at the reporting unit level using a fair value approach. The Company is required to test for impairment at least annually, absent a triggering event, which could include a significant decline in operating performance that would require an impairment assessment. Absent any impairment indicators, the Company performs its goodwill impairment testing during the fourth quarter of each year. The Company recognizes an impairment charge for any amount by which the carrying amount of goodwill exceeds its fair value.

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

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

#### ***Medical Claims Liability***

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

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

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

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

The Company reviews actual and anticipated experience compared to the assumptions used to establish medical costs. The Company establishes premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with the method of acquiring, servicing and measuring the profitability of such contracts and expected investment income is excluded. In December 2023, the Company recorded a premium deficiency reserve of \$250 million related to the 2024 Medicare Advantage contract year. In December 2024, the Company recorded a premium deficiency reserve of \$92 million related to the 2025 Medicare Advantage contract year.

### ***Revenue Recognition***

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

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

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

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

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

The Company's specialty companies generate revenues under contracts with state and federal programs, healthcare organizations and other commercial organizations, as well as from its own subsidiaries. Revenues are recognized when the related services are provided, when inventory is shipped, or as ratably earned over the covered period of services. For performance-based measures in the Company's contracts, revenue is recognized as data sufficient to measure performance is available. The Company recognizes revenue related to administrative services under the TRICARE government-sponsored Managed Care Support Contract for the Department of Defense (DoD's) TRICARE program on a straight-line basis over the option period, when the fees become fixed and determinable. The TRICARE contract includes various performance-based measures. For each of the measures, an estimate of the amount that has been earned is made at each interim date, and revenue is recognized accordingly. The Company concluded serving members at the end of 2024 upon the expiration of its TRICARE Managed Care Support Contract.

Some states enact premium taxes, similar assessments and provider pass-through payments, collectively premium taxes, and these taxes are recorded as a separate component of both revenues and operating expenses. For certain products, premium taxes and state assessments are not pass-through payments and are recorded as premium revenue and premium tax expense in the Consolidated Statements of Operations.

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

### ***Affordable Care Act***

The Affordable Care Act (ACA) established risk spreading premium stabilization programs as well as minimum MLR and cost sharing reductions (CSRs). The Company's accounting policies for the programs are as follows:

#### ***Risk Adjustment***

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

#### ***Minimum Medical Loss Ratio***

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

#### ***Cost Sharing Reductions***

The ACA directs issuers to reduce the Company's members' cost sharing for essential health benefits for individuals with Federal Poverty Levels (FPLs) between 100% and 250% who are enrolled in a silver tier product; eliminate cost sharing for Indians/Alaska Natives with a FPL less than 300% and eliminate cost sharing for Indians/Alaska Natives regardless of FPL when services are provided by an Indian Health Service. In October 2017, the Trump Administration issued an executive order that immediately ceased payments of CSRs to issuers, and beginning in 2018, premium rates for Health Insurance Marketplace were set without factoring in the cost sharing subsidy payments from the federal government. In 2024, the Company reached an agreement with the federal government to retroactively compensate the Company for the difference between its actual CSR experience and its pricing assumptions for 2018 through 2020.

**Premium and Trade Receivables and Unearned Revenue**

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

Activity in the allowance for uncollectible accounts is summarized below (\$ in millions):

	Year Ended December 31,		
	2024	2023	2022
Balance, January 1	\$ 120	\$ 130	\$ 139
Amounts charged to expense	68	58	70
Write-offs of uncollectible receivables	(77)	(68)	(79)
Balance, December 31	<u>\$ 111</u>	<u>\$ 120</u>	<u>\$ 130</u>

**Significant Customers**

The Company receives the majority of its revenues under contracts or subcontracts with state Medicaid managed care programs. None of the Company's customers exceeded 10% of total annual revenues for the years ended December 31, 2024, 2023 and 2022.

**Other Income (Expense)**

Other income (expense) consists routinely of investment income, interest expense and equity method earnings from investments. Investment income is derived from the Company's cash, cash equivalents, restricted deposits and investments. Interest expense relates to borrowings under the senior notes, credit facilities, mortgage and construction loans and capital leases. Further, other income (expense) includes gains or losses on sales of investments, divestitures and acquisitions as well as debt extinguishment costs.

**Income Taxes**

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

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

**Contingencies**

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

**Stock Based Compensation**

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

### ***Recently Adopted Accounting Guidance***

In November 2023, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2023-07 - Segment Reporting: Improvements to Reportable Segment Disclosures which is intended to improve reportable segment disclosure requirements, primarily through enhanced disclosures about significant expenses. The amendments will require public entities to disclose significant segment expenses that are regularly provided to the chief operating decision-maker and included within segment profit and loss. The new standard is effective for annual periods beginning after December 15, 2023, and for interim periods within fiscal years beginning after December 15, 2024. The Company adopted the new guidance in the fourth quarter of 2024.

In December 2023, the FASB issued ASU 2023-09 - Income taxes: Improvements to Income Tax Disclosures which includes amendments that further enhance income tax disclosures, primarily through standardization and disaggregation of rate reconciliation categories and income taxes paid by jurisdiction. The new standard is effective for annual periods beginning after December 15, 2024. The Company early adopted the new guidance in the fourth quarter of 2024, as permissible by the ASU.

### ***Recent Accounting Guidance Not Yet Adopted***

In November 2024, the FASB issued ASU 2024-03 - Income Statement - Reporting Comprehensive Income: Disaggregation of Income Statement Expenses which expands disclosures about specific expense categories presented on the face of the Statement of Operations. The new standard is effective for annual periods beginning after December 15, 2026, and interim periods beginning after December 15, 2027. The Company is currently evaluating the effect of the new disclosure requirements.

## **3. Acquisitions and Divestitures**

### ***Spanish and Central European Divestiture***

On November 16, 2022, the Company completed the divestiture of its ownership stakes in its Spanish and Central European businesses, including Ribera Salud, Torrejón Salud and Pro Diagnostics Group.

During 2022, the Company recorded an impairment charge primarily related to intangible assets and goodwill associated with the divestiture of \$163 million, or \$140 million after-tax. In 2023, the Company recognized an additional loss on sale of \$13 million, or \$10 million after-tax, which is included in investment and other income in the Consolidated Statements of Operations.

### ***Magellan Rx Divestiture***

On December 2, 2022, the Company completed the divestiture of Magellan Rx for \$1,337 million. The Company recognized a gain of \$269 million, or \$99 million after-tax, which is included in investment and other income in the Consolidated Statements of Operations.

During 2023, the Company recorded a reduction to the previously reported gain on the divestiture of \$22 million, or \$10 million after-tax, due to the finalization of working capital adjustments.

### ***Magellan Specialty Health Divestiture***

On January 20, 2023, the Company completed the divestiture of Magellan Specialty Health for \$646 million in cash and stock, including an estimated working capital adjustment, and recognized a gain of \$79 million, or \$68 million after-tax. The stock consideration was subsequently sold in April 2023 for cash proceeds of \$245 million.

During 2024, the Company recorded an additional gain on the previously reported divestiture of Magellan Specialty Health of \$83 million for achievement of contingent consideration related to the sale and finalization of working capital adjustments, which is included in investment and other income in the Consolidated Statements of Operations.

### ***Centurion Divestiture***

On January 10, 2023, the Company signed and closed a definitive agreement to divest Centurion. During 2022, the Company recorded an impairment charge related to goodwill and other current assets associated with the divestiture of \$259 million, or \$181 million after-tax. During 2023, the Company recognized a gain of \$15 million, or \$10 million after-tax, reflecting additional proceeds for contingent consideration, partially offset by net working capital adjustments. The gain is included in investment and other income in the Consolidated Statements of Operations.

### ***HealthSmart Divestiture***

On January 5, 2023, the Company completed the divestiture of HealthSmart. During 2022, the Company recorded an impairment charge related to goodwill associated with the divestiture of \$36 million, or \$27 million after-tax.

### ***Apixio Divestiture***

On June 13, 2023, the Company completed the divestiture of its majority stake in Apixio. During 2023, the Company recognized a pre-tax gain of \$93 million, or \$67 million after-tax, which is included in investment and other income in the Consolidated Statements of Operations.

### ***Circle Health Group Divestiture***

On August 28, 2023, the Company signed a definitive agreement to sell Circle Health, one of the U.K.'s largest independent hospital operators, which is included in the Other segment. As of December 31, 2023, the assets and liabilities of Circle Health were considered held for sale resulting in \$3,897 million of assets held for sale in other current assets and \$3,094 million of liabilities held for sale in accounts payable and accrued expenses in the Consolidated Balance Sheets. The majority of the held for sale assets were previously reported as other long-term assets, goodwill and property, software and equipment. The majority of the liabilities were previously reported as debt and other long-term liabilities.

In accordance with the signed definitive agreement in the third quarter of 2023, and subsequently updated in the fourth quarter of 2023, the Company recorded impairment charges related to goodwill associated with the pending divestiture totaling \$292 million, or \$258 million after-tax.

In order to manage the foreign exchange risk on the sale price associated with the pending divestiture of Circle Health, in August 2023 the Company entered into a foreign currency swap agreement for a notional amount of \$931 million, to sell £740 million. The swap agreement was formally designated and qualified as a cash flow hedge. The swap expired on the earlier of the divestiture closing date or March 28, 2024. The gain or loss due to changes in the fair value of the foreign currency swap was recorded in other comprehensive income until the Circle Health divestiture closed, at which time the gain or loss was recorded in earnings to the same line in the Consolidated Statements of Operations as the gain or loss on sale. The fair value of the swap agreement as of December 31, 2023 was \$13 million, which was recorded in accounts payable and accrued expenses in the Consolidated Balance Sheets.

On January 12, 2024, the Company completed the divestiture for \$931 million and settled the foreign currency swap. Upon closing the divestiture, the Company settled the foreign currency swap and recorded a corresponding gain of \$20 million, which includes the cumulative translation adjustment previously recorded in accumulated other comprehensive income in the Consolidated Balance Sheet. The gain is included in investment and other income in the Consolidated Statements of Operations. During the year ended December 31, 2024, the Company realized a net tax benefit of approximately \$40 million on the loss recognized on the divestiture.

### ***Operose Health Group Divestiture***

In November 2023, the Company signed a definitive agreement to sell Operose Health and completed the divestiture on December 28, 2023. During 2023, the Company recorded impairment charges to Operose Health primarily related to goodwill, intangible assets and property, software and equipment of \$140 million, or \$128 million after-tax based on market indicators of fair value.

### ***Collaborative Health Systems Divestiture***

In July 2024, the Company entered into a definitive agreement to sell CHS, a management services organization, which is included in the Other segment.

On October 4, 2024, the Company completed the previously announced sale of CHS. During 2024, the Company recognized a pre-tax gain of \$17 million, or \$13 million after-tax, which is included in investment and other income in the Consolidated Statements of Operations.

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

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

	December 31, 2024				December 31, 2023			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Debt securities:								
U.S. Treasury securities and obligations of U.S. government corporations and agencies	\$ 593	\$ 2	\$ (4)	\$ 591	\$ 403	\$ —	\$ (8)	\$ 395
Corporate securities	10,820	47	(360)	10,507	9,984	78	(461)	9,601
Restricted certificates of deposit	4	—	—	4	4	—	—	4
Restricted cash equivalents	93	—	—	93	259	—	—	259
Short-term time deposits	425	—	—	425	746	—	—	746
Municipal securities	4,174	7	(151)	4,030	4,135	21	(171)	3,985
Asset-backed securities	1,820	13	(21)	1,812	1,665	8	(35)	1,638
Residential mortgage-backed securities	1,807	1	(129)	1,679	1,503	7	(103)	1,407
Commercial mortgage-backed securities	1,298	3	(62)	1,239	1,149	5	(82)	1,072
Equity securities	14	—	—	14	17	—	—	17
Private equity investments	851	—	—	851	833	—	—	833
Life insurance contracts	196	—	—	196	174	—	—	174
Total	\$ 22,095	\$ 73	\$ (727)	\$ 21,441	\$ 20,872	\$ 119	\$ (860)	\$ 20,131

The Company's investments are debt securities classified as available-for-sale with the exception of equity securities, certain private equity investments and life insurance contracts. Private equity investments include direct investments in private equity securities as well as private equity funds. In December 2024, the Company impaired a private equity investment for \$50 million. The Company's investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets with a focus on high credit quality securities. The Company limits the size of investment in any single issuer other than U.S. treasury securities and obligations of U.S. government corporations and agencies. As of December 31, 2024, 99% of the Company's investments in rated securities carry an investment grade rating by nationally recognized statistical rating organizations. At December 31, 2024, the Company held certificates of deposit, equity securities, private equity investments and life insurance contracts, which did not carry a credit rating. Accrued interest income on available-for-sale debt securities was \$178 million and \$153 million at December 31, 2024 and 2023, respectively, and is included in other current assets in the Consolidated Balance Sheets.

The Company's residential mortgage-backed securities are primarily issued by the Federal National Mortgage Association, Government National Mortgage Association or Federal Home Loan Mortgage Corporation, which carry implicit or explicit guarantees of the U.S. government. The Company's commercial mortgage-backed securities are primarily senior tranches with a weighted average rating of AA+ and a weighted average duration of 3 years at December 31, 2024.

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

	December 31, 2024				December 31, 2023			
	Less Than 12 Months		12 Months or More		Less Than 12 Months		12 Months or More	
	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	\$ (1)	\$ 60	\$ (3)	\$ 144	\$ —	\$ 79	\$ (8)	\$ 232
Corporate securities	(41)	2,621	(319)	4,782	(6)	658	(455)	6,260
Municipal securities	(16)	1,217	(135)	2,073	(4)	553	(167)	2,237
Asset-backed securities	(4)	301	(17)	331	(2)	197	(33)	855
Residential mortgage-backed securities	(18)	786	(111)	738	(2)	153	(101)	814
Commercial mortgage-backed securities	(4)	210	(58)	666	(2)	114	(80)	754
Short-term time deposits	—	—	—	—	—	31	—	—
<b>Total</b>	<b>\$ (84)</b>	<b>\$ 5,195</b>	<b>\$ (643)</b>	<b>\$ 8,734</b>	<b>\$ (16)</b>	<b>\$ 1,785</b>	<b>\$ (844)</b>	<b>\$ 11,152</b>

As of December 31, 2024, the gross unrealized losses were generated from 5,276 positions out of a total of 6,750 positions. The change in fair value of available-for-sale debt securities is primarily a result of movement in interest rates subsequent to the purchase of the security.

For each security in an unrealized loss position, the Company assesses whether it intends to sell the security or if it is more likely than not the Company will be required to sell the security before recovery of the amortized cost basis for reasons such as liquidity, contractual or regulatory purposes. If the security meets this criterion, the decline in fair value is recorded in earnings. The Company does not intend to sell these securities prior to maturity and it is not likely that the Company will be required to sell these securities prior to maturity; therefore, the Company did not record an impairment for these securities.

In addition, the Company monitors available-for-sale debt securities for credit losses. Certain investments have experienced a decline in fair value due to changes in credit quality, market interest rates and/or general economic conditions. The Company recognizes an allowance when evidence demonstrates that the decline in fair value is credit related. Evidence of a credit-related loss may include rating agency actions, adverse conditions specifically related to the security or failure of the issuer of the security to make scheduled payments.

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

	December 31, 2024				December 31, 2023			
	Investments		Restricted Deposits		Investments		Restricted Deposits	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value
One year or less	\$ 2,383	\$ 2,365	\$ 477	\$ 475	\$ 2,308	\$ 2,284	\$ 566	\$ 564
One year through five years	7,799	7,563	610	593	7,738	7,431	527	504
Five years through ten years	4,343	4,172	301	291	3,905	3,735	298	283
Greater than ten years	165	160	31	31	155	154	34	35
Asset-backed securities	4,925	4,730	—	—	4,317	4,117	—	—
<b>Total</b>	<b>\$ 19,615</b>	<b>\$ 18,990</b>	<b>\$ 1,419</b>	<b>\$ 1,390</b>	<b>\$ 18,423</b>	<b>\$ 17,721</b>	<b>\$ 1,425</b>	<b>\$ 1,386</b>

Actual maturities may differ from contractual maturities due to call or prepayment options. Equity securities, private equity investments and life insurance contracts are excluded from the table above because they do not have a contractual maturity. The Company has an option to redeem substantially all of the securities included in the greater than ten years category listed above at amortized cost.

## 5. Fair Value Measurements

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

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

The following table summarizes fair value measurements by level at December 31, 2024, for assets and liabilities measured at fair value on a recurring basis (\$ in millions):

	<b>Level I</b>	<b>Level II</b>	<b>Level III</b>	<b>Total</b>
<b>Assets</b>				
Cash and cash equivalents	\$ 14,063	\$ —	\$ —	\$ 14,063
Investments:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	\$ 58	\$ —	\$ —	\$ 58
Corporate securities	—	10,505	—	10,505
Municipal securities	—	3,272	—	3,272
Short-term time deposits	—	425	—	425
Asset-backed securities	—	1,812	—	1,812
Residential mortgage-backed securities	—	1,679	—	1,679
Commercial mortgage-backed securities	—	1,239	—	1,239
Equity securities	13	1	—	14
Total investments	\$ 71	\$ 18,933	\$ —	\$ 19,004
Restricted deposits:				
Cash and cash equivalents	\$ 93	\$ —	\$ —	\$ 93
U.S. Treasury securities and obligations of U.S. government corporations and agencies	533	—	—	533
Corporate securities	—	2	—	2
Certificates of deposit	—	4	—	4
Municipal securities	—	758	—	758
Total restricted deposits	\$ 626	\$ 764	\$ —	\$ 1,390
Total assets at fair value	\$ 14,760	\$ 19,697	\$ —	\$ 34,457

The following table summarizes fair value measurements by level at December 31, 2023, for assets and liabilities measured at fair value on a recurring basis (\$ in millions):

	<u>Level I</u>	<u>Level II</u>	<u>Level III</u>	<u>Total</u>
<b>Assets</b>				
Cash and cash equivalents	\$ 17,193	\$ —	\$ —	\$ 17,193
Investments:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	\$ 62	\$ —	\$ —	\$ 62
Corporate securities	—	9,564	—	9,564
Municipal securities	—	3,232	—	3,232
Short-term time deposits	—	746	—	746
Asset-backed securities	—	1,638	—	1,638
Residential mortgage-backed securities	—	1,407	—	1,407
Commercial mortgage-backed securities	—	1,072	—	1,072
Equity securities	15	2	—	17
Total investments	<u>\$ 77</u>	<u>\$ 17,661</u>	<u>\$ —</u>	<u>\$ 17,738</u>
Restricted deposits:				
Cash and cash equivalents	\$ 259	\$ —	\$ —	\$ 259
U.S. Treasury securities and obligations of U.S. government corporations and agencies	333	—	—	333
Corporate securities	—	37	—	37
Certificates of deposit	—	4	—	4
Municipal securities	—	753	—	753
Total restricted deposits	<u>\$ 592</u>	<u>\$ 794</u>	<u>\$ —</u>	<u>\$ 1,386</u>
Total assets at fair value	<u>\$ 17,862</u>	<u>\$ 18,455</u>	<u>\$ —</u>	<u>\$ 36,317</u>
<b>Liabilities</b>				
Accounts payable and accrued expenses:				
Foreign currency swap agreement	\$ —	\$ 13	\$ —	\$ 13
Total liabilities at fair value	<u>\$ —</u>	<u>\$ 13</u>	<u>\$ —</u>	<u>\$ 13</u>

The Company utilizes matrix pricing services to estimate fair value for securities which are not actively traded on the measurement date. The Company designates these securities as Level II fair value measurements. In addition, the aggregate carrying amount of the Company's private equity investments and life insurance contracts, which approximates fair value, was \$1,047 million and \$1,007 million as of December 31, 2024 and December 31, 2023, respectively.

## 6. Property, Software and Equipment

Property, software and equipment consist of the following (\$ in millions):

	<b>December 31, 2024</b>	<b>December 31, 2023</b>
Computer software	\$ 3,051	\$ 2,631
Computer hardware	535	542
Buildings	523	534
Furniture and office equipment	332	304
Leasehold improvements	273	252
Land	156	156
Property, software and equipment, at cost	4,870	4,419
Less: accumulated depreciation	(2,803)	(2,400)
Property, software and equipment, net	<u>\$ 2,067</u>	<u>\$ 2,019</u>

Depreciation expense for the years ended December 31, 2024, 2023 and 2022 was \$549 million, \$575 million and \$614 million, respectively.

During the second quarter of 2022, in connection with the adoption of a more modern, flexible work environment, the Company undertook a real estate optimization initiative to evaluate future real estate needs and downsize its real estate footprint for owned and leased properties. As a result of this evaluation, the Company substantially changed the use or abandoned various properties and assessed for impairment. The Company engaged a third-party real estate specialist to determine the fair value of its owned properties. The valuation primarily considered comparable properties in each market as well as future cash flows.

As a result of the optimization, the Company recognized impairment charges related to owned real estate and fixed assets related to leased real estate of \$57 million and \$1,050 million for the years ended December 31, 2023 and 2022, respectively. The remainder of the \$97 million and \$1,627 million impairment charges for the years ended December 31, 2023 and 2022, respectively, relate to right-of-use (ROU) asset impairments, which is included within other long-term assets in the Consolidated Balance Sheets, refer to Note 11. *Leases*. Additionally, during 2024, the Company sold an owned property for a pre-tax gain of \$24 million.

## 7. Goodwill and Intangible Assets

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

	<b>Medicaid</b>	<b>Medicare</b>	<b>Commercial</b>	<b>Other</b>	<b>Consolidated Total</b>
Balance, December 31, 2022	\$ 10,198	\$ 1,592	\$ 5,424	\$ 1,598	\$ 18,812
Divestitures	—	—	—	(912)	(912)
Impairments	—	—	—	(392)	(392)
Translation impact	—	—	—	50	50
Balance, December 31, 2023	\$ 10,198	\$ 1,592	\$ 5,424	\$ 344	\$ 17,558
Current year activity	—	—	—	—	—
Balance, December 31, 2024	<u>\$ 10,198</u>	<u>\$ 1,592</u>	<u>\$ 5,424</u>	<u>\$ 344</u>	<u>\$ 17,558</u>

In 2023, divestiture related activity in goodwill included the completed divestiture of Apixio as well as \$760 million of goodwill reclassified to other current assets associated with the divestiture of Circle Health, which was considered held for sale as of December 31, 2023.

The Company's Other segment impairments in 2023 were driven by the Circle Health and Operose Health divestitures.

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

			Weighted Average Useful Life in Years	
	2024	2023	2024	2023
Purchased contract rights and customer relationships	\$ 7,845	\$ 7,845	13.5	13.5
Trade names	943	943	15.6	15.6
Provider contracts	612	612	14.0	14.0
Developed technologies	298	298	4.4	4.4
Intangible assets	9,698	9,698	13.4	13.4
Less: accumulated amortization				
Purchased contract rights and customer relationships	(3,348)	(2,768)		
Trade names	(383)	(320)		
Provider contracts	(271)	(227)		
Developed technologies	(287)	(282)		
Total accumulated amortization	(4,289)	(3,597)		
Intangible assets, net	\$ 5,409	\$ 6,101		

Amortization expense was \$692 million, \$718 million and \$817 million for the years ended December 31, 2024, 2023 and 2022, respectively. Estimated total amortization expense related to the December 31, 2024 intangible assets for each of the five succeeding fiscal years is as follows (\$ in millions):

	Estimated Total Amortization Expense
2025	\$ 690
2026	673
2027	663
2028	662
2029	558

## 8. Medical Claims Liability

The following table summarizes the change in medical claims liability for the year ended December 31, 2024 (\$ in millions):

	<u>Medicaid</u>	<u>Medicare</u>	<u>Commercial</u>	<u>Other</u>	<u>Consolidated Total</u>
<b>Balance, January 1, 2024</b>	\$ 10,814	\$ 3,612	\$ 3,460	\$ 114	\$ 18,000
Less: Reinsurance recoverables	5	—	44	—	49
Balance, January 1, 2024, net	10,809	3,612	3,416	114	17,951
<b>Incurred related to:</b>					
Current year	78,886	21,170	26,548	1,708	128,312
Prior years	(1,370)	(575)	(509)	7	(2,447)
Total incurred	77,516	20,595	26,039	1,715	125,865
<b>Paid related to:</b>					
Current year	69,351	18,036	22,547	1,522	111,456
Prior years	8,693	2,655	2,492	119	13,959
Total paid	78,044	20,691	25,039	1,641	125,415
Plus: Premium deficiency reserve	—	(158)	—	—	(158)
Balance, December 31, 2024, net	10,281	3,358	4,416	188	18,243
Plus: Reinsurance recoverables	18	—	47	—	65
<b>Balance, December 31, 2024</b>	<u>\$ 10,299</u>	<u>\$ 3,358</u>	<u>\$ 4,463</u>	<u>\$ 188</u>	<u>\$ 18,308</u>

The following table summarizes the change in medical claims liability for the year ended December 31, 2023 (\$ in millions):

	<u>Medicaid</u>	<u>Medicare</u>	<u>Commercial</u>	<u>Other</u>	<u>Consolidated Total</u>
<b>Balance, January 1, 2023</b>	\$ 11,253	\$ 3,431	\$ 1,921	\$ 140	\$ 16,745
Less: Reinsurance recoverables	7	—	19	—	26
Balance, January 1, 2023, net	11,246	3,431	1,902	140	16,719
<b>Incurred related to:</b>					
Current year	79,747	19,487	19,966	1,480	120,680
Prior years	(1,537)	(343)	(150)	(6)	(2,036)
Total incurred	78,210	19,144	19,816	1,474	118,644
<b>Paid related to:</b>					
Current year	69,904	16,631	16,823	1,367	104,725
Prior years	8,743	2,582	1,479	133	12,937
Total paid	78,647	19,213	18,302	1,500	117,662
Plus: Premium deficiency reserve	—	250	—	—	250
Balance, December 31, 2023, net	10,809	3,612	3,416	114	17,951
Plus: Reinsurance recoverables	5	—	44	—	49
<b>Balance, December 31, 2023</b>	<u>\$ 10,814</u>	<u>\$ 3,612</u>	<u>\$ 3,460</u>	<u>\$ 114</u>	<u>\$ 18,000</u>

The following table summarizes the change in medical claims liability for the year ended December 31, 2022 (\$ in millions):

	<u>Medicaid</u>	<u>Medicare</u>	<u>Commercial</u>	<u>Other</u>	<u>Consolidated Total</u>
<b>Balance, January 1, 2022</b>	\$ 9,845	\$ 2,286	\$ 2,014	\$ 98	\$ 14,243
Less: Reinsurance recoverables	23	—	—	—	23
Balance, January 1, 2022, net	9,822	2,286	2,014	98	14,220
Acquisitions and divestitures	—	—	—	105	105
Incurred related to:					
Current year	76,344	19,474	14,296	2,782	112,896
Prior years	(1,046)	(102)	(204)	(15)	(1,367)
Total incurred	75,298	19,372	14,092	2,767	111,529
Paid related to:					
Current year	66,221	16,275	12,556	2,747	97,799
Prior years	7,653	1,952	1,648	83	11,336
Total paid	73,874	18,227	14,204	2,830	109,135
Balance, December 31, 2022, net	11,246	3,431	1,902	140	16,719
Plus: Reinsurance recoverables	7	—	19	—	26
<b>Balance, December 31, 2022</b>	<u>\$ 11,253</u>	<u>\$ 3,431</u>	<u>\$ 1,921</u>	<u>\$ 140</u>	<u>\$ 16,745</u>

Reinsurance recoverables related to medical claims are included in premium and trade receivables. Changes in estimates of incurred claims for prior years were primarily attributable to reserving under moderately adverse conditions, including residual pandemic impacts. Additionally, as a result of minimum MLR and other return of premium programs, the Company recorded approximately \$243 million, \$382 million and \$198 million of the "Incurred related to: Prior years" as a reduction to premium revenues in 2024, 2023 and 2022, respectively. Further, claims processing and coordination of benefits initiatives yielded claim payment recoveries related to dates of service from prior years.

Changes in medical utilization, claims submission patterns, and cost trends and the effect of population health management initiatives may also contribute to changes in medical claim liability estimates. While the Company has evidence that population health management initiatives are effective on a case by case basis, population health management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the population health management initiative are not known by the Company. Additionally, certain population health management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the population health management initiative changed the behavior cannot be determined. Because of the complexity of its business, the number of states in which it operates and the volume of claims that it processes, the Company is unable to practically quantify the impact of these initiatives on its changes in estimates of IBNR.

The Company reviews actual and anticipated experience compared to the assumptions used to establish medical costs. The Company establishes premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with the method of acquiring, servicing and measuring the profitability of such contracts and expected investment income is excluded. In December 2023, the Company recorded a premium deficiency reserve of \$250 million related to the 2024 Medicare Advantage contract year. In December 2024, the Company recorded a premium deficiency reserve of \$92 million related to the 2025 Medicare Advantage contract year.

Information about incurred and paid claims development as of December 31, 2024 is included in the table below. The claims development information for all periods preceding the most recent reporting period is considered required supplementary information.

Consolidated incurred and paid claims development as of December 31, 2024 is as follows (\$ in millions):

<b>Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance</b>					
<b>For the Year Ended December 31,</b>					
<b>Claim Year</b>	<b>2022 (unaudited)</b>		<b>2023 (unaudited)</b>		<b>2024</b>
2022	\$	112,896	\$	110,870	\$ 110,394
2023				120,680	118,709
2024					128,312
				Total incurred claims	\$ 357,415
<b>Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance</b>					
<b>For the Year Ended December 31,</b>					
<b>Claim Year</b>	<b>2022 (unaudited)</b>		<b>2023 (unaudited)</b>		<b>2024</b>
2022	\$	97,799	\$	109,680	\$ 110,097
2023				104,725	117,635
2024					111,456
				Total payment of incurred claims	339,188
				All outstanding liabilities prior to 2022, net of reinsurance	174
				Medical claims liability, net of reinsurance	\$ 18,401

Incurred and paid claims development for the Medicaid segment as of December 31, 2024 is as follows (\$ in millions):

<b>Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance</b>					
<b>For the Year Ended December 31,</b>					
<b>Claim Year</b>	<b>2022 (unaudited)</b>		<b>2023 (unaudited)</b>		<b>2024</b>
2022	\$	76,344	\$	74,861	\$ 74,722
2023				79,747	78,517
2024					78,885
				Total incurred claims	\$ 232,124
<b>Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance</b>					
<b>For the Year Ended December 31,</b>					
<b>Claim Year</b>	<b>2022 (unaudited)</b>		<b>2023 (unaudited)</b>		<b>2024</b>
2022	\$	66,220	\$	74,125	\$ 74,608
2023				69,904	77,952
2024					69,351
				Total payment of incurred claims	221,911
				All outstanding liabilities prior to 2022, net of reinsurance	68
				Medical claims liability, net of reinsurance	\$ 10,281

Incurred and paid claims development for the Medicare segment as of December 31, 2024 is as follows (\$ in millions):

<b>Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance</b>					
<b>For the Year Ended December 31,</b>					
<b>Claim Year</b>	<b>2022 (unaudited)</b>		<b>2023 (unaudited)</b>		<b>2024</b>
2022	\$	19,475	\$	19,124	\$ 19,027
2023				19,487	19,008
2024					21,171
				Total incurred claims	\$ 59,206
<b>Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance</b>					
<b>For the Year Ended December 31,</b>					
<b>Claim Year</b>	<b>2022 (unaudited)</b>		<b>2023 (unaudited)</b>		<b>2024</b>
2022	\$	16,276	\$	18,818	\$ 18,942
2023				16,631	18,778
2024					18,036
				Total payment of incurred claims	55,756
				All outstanding liabilities prior to 2022, net of reinsurance	66
				Medical claims liability, net of reinsurance	\$ 3,516

Incurred and paid claims development for the Commercial segment as of December 31, 2024 is as follows (\$ in millions):

<b>Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance</b>					
<b>For the Year Ended December 31,</b>					
<b>Claim Year</b>	<b>2022 (unaudited)</b>		<b>2023 (unaudited)</b>		<b>2024</b>
2022	\$	14,296	\$	14,110	\$ 13,870
2023				19,966	19,698
2024					26,548
				Total incurred claims	\$ 60,116
<b>Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance</b>					
<b>For the Year Ended December 31,</b>					
<b>Claim Year</b>	<b>2022 (unaudited)</b>		<b>2023 (unaudited)</b>		<b>2024</b>
2022	\$	12,556	\$	13,963	\$ 13,773
2023				16,823	19,420
2024					22,547
				Total payment of incurred claims	55,740
				All outstanding liabilities prior to 2022, net of reinsurance	40
				Medical claims liability, net of reinsurance	\$ 4,416

Incurred and paid claims development for the Other segment as of December 31, 2024 is as follows (\$ in millions):

<b>Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance</b>						
<b>For the Year Ended December 31,</b>						
<b>Claim Year</b>	<b>2022 (unaudited)</b>		<b>2023 (unaudited)</b>		<b>2024</b>	
2022	\$	2,781	\$	2,775	\$	2,775
2023				1,480		1,486
2024						1,708
				Total incurred claims	\$	5,969

<b>Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance</b>						
<b>For the Year Ended December 31,</b>						
<b>Claim Year</b>	<b>2022 (unaudited)</b>		<b>2023 (unaudited)</b>		<b>2024</b>	
2022	\$	2,747	\$	2,774	\$	2,774
2023				1,367		1,485
2024						1,522
				Total payment of incurred claims		5,781
				All outstanding liabilities prior to 2022, net of reinsurance		—
				Medical claims liability, net of reinsurance	\$	188

Incurred claims and allocated claim adjustment expenses, net of reinsurance, total IBNR plus expected development on reported claims and cumulative claims data as of December 31, 2024 are included in the following table. For claims frequency information summarized below, a claim is defined as the financial settlement of a single medical event in which remuneration was paid to the servicing provider. Total IBNR plus expected development on reported claims represents estimates for claims incurred but not reported, development on reported claims and estimates for the costs necessary to process unpaid claims at the end of each period. The Company estimates its liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Consolidated information is summarized as follows (in millions):

<b>December 31, 2024</b>					
	<b>Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance</b>		<b>Total IBNR Plus Expected Development on Reported Claims</b>	<b>Cumulative Paid Claims</b>	
2022	\$	110,394	\$	3	638.0
2023		118,709		383	623.6
2024		128,312		12,079	641.3

Information for the Medicaid segment is summarized as follows (in millions):

<b>December 31, 2024</b>					
	<b>Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance</b>		<b>Total IBNR Plus Expected Development on Reported Claims</b>	<b>Cumulative Paid Claims</b>	
2022	\$	74,722	\$	3	370.9
2023		78,517		218	345.6
2024		78,885		6,968	300.1

Information for the Medicare segment is summarized as follows (in millions):

December 31, 2024				
	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		Total IBNR Plus Expected Development on Reported Claims	Cumulative Paid Claims
2022	\$	19,027	\$ —	204.8
2023		19,008	102	200.6
2024		21,171	1,724	253.0

Information for the Commercial segment is summarized as follows (in millions):

December 31, 2024				
	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		Total IBNR Plus Expected Development on Reported Claims	Cumulative Paid Claims
2022	\$	13,870	\$ —	57.5
2023		19,698	62	72.9
2024		26,548	3,211	83.0

Information for the Other segment is summarized as follows (in millions):

December 31, 2024				
	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		Total IBNR Plus Expected Development on Reported Claims	Cumulative Paid Claims
2022	\$	2,775	\$ —	4.8
2023		1,486	1	4.5
2024		1,708	176	5.2

## 9. Affordable Care Act

The ACA established risk spreading premium stabilization programs as well as a minimum annual MLR and CSRs.

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

	December 31, 2024	December 31, 2023
Risk adjustment receivable	\$ 1,434	\$ 893
Risk adjustment payable	(1,605)	(2,553)
Minimum medical loss ratio	(688)	(164)
Cost sharing reduction receivable	305	—
Cost sharing reduction payable	(74)	(114)

In July 2024, CMS announced the final risk adjustment transfers for the 2023 benefit year. As a result of the announcement, the risk adjustment net payable was decreased by \$1,475 million in the twelve months ended December 31, 2024. After consideration of minimum MLR and other related impacts, which includes the effect to the 2024 benefit year, the net pre-tax benefit recognized was \$853 million for the year ended December 31, 2024.

In October 2017, the Trump Administration issued an executive order that immediately ceased payments of CSRs to issuers, and beginning in 2018, premium rates for Health Insurance Marketplace were set without factoring in the cost sharing subsidy payments from the federal government. In 2024, the Company reached an agreement with the federal government to retroactively compensate the Company \$299 million (gross) for the difference between its actual CSR experience and its pricing assumptions for 2018 through 2020.

## 10. Debt

Debt consists of the following (\$ in millions):

	<b>December 31, 2024</b>	<b>December 31, 2023</b>
\$2,500 million 4.25% Senior Notes, due December 15, 2027	\$ 2,398	\$ 2,395
\$2,300 million 2.45% Senior Notes, due July 15, 2028	2,302	2,303
\$3,500 million 4.625% Senior Notes, due December 15, 2029	3,277	3,277
\$2,000 million 3.375% Senior Notes, due February 15, 2030	2,000	2,000
\$2,200 million 3.00% Senior Notes, due October 15, 2030	2,200	2,200
\$2,200 million 2.50% Senior Notes, due March 1, 2031	2,200	2,200
\$1,300 million 2.625% Senior Notes, due August 1, 2031	1,300	1,300
Total senior notes	15,677	15,675
Term Loan Facility	2,006	2,115
Revolving Credit Agreement	950	150
Finance leases and other	—	11
Debt issuance costs	(100)	(122)
Total debt	18,533	17,829
Less: current portion	(110)	(119)
Long-term debt	\$ 18,423	\$ 17,710

### *Senior Notes*

The indentures governing the senior notes listed in the table above contain restrictive covenants of Centene Corporation. At December 31, 2024, the Company was in compliance with all covenants.

### *Circle Health Debt Refinancing*

In May 2022, the Company refinanced certain debt agreements for its Circle Health subsidiary with a new £250 million credit facility maturing in May 2025. The Company recognized a \$13 million pre-tax gain on the extinguishment of the existing debt. As of December 31, 2023, £150 million was drawn on the facility, and was included in accounts payable and accrued expenses in the Consolidated Balance Sheets as a liability held for sale. The facility is guaranteed by the Company and has similar borrowing rates and covenants to the Company's Revolving Credit Agreement, except it uses the Sterling Overnight Index Average (SONIA) as the reference rate for the interest rate payable. In January 2024, the Company completed the divestiture of Circle Health and terminated the credit facility.

### *Revolving Credit Facility and Term Loan Credit Facility*

In May 2023, the Company entered into a first amendment to the Company's Fourth Amended and Restated Credit Agreement. The amendment removed and replaced the interest rate benchmark based on the London Interbank Offered Rate (LIBOR) and related LIBOR-based mechanics applicable to U.S. dollar borrowings under the Amended and Restated Credit Agreement with an interest rate benchmark based on the Secured Overnight Financing Rate (SOFR) (including a customary credit spread adjustment) and related SOFR-based mechanics. Additionally, the amendment removed certain provisions which required the Company to make certain mandatory prepayments of the Term Loan Facility.

The Company has (i) unsecured \$2,000 million multi-currency revolving credit facility (the Revolving Credit Facility), which includes a \$300 million sub-limit for letters of credit and a \$200 million sub-limit for swingline loans and (ii) a \$2,200 million unsecured delayed-draw term loan facility (the Term Loan Facility, and together with the Revolving Credit Facility, the Company Credit Facility). Borrowings under the Revolving Credit Facility bear interest, at the Company's option, at SOFR, SONIA, Euro Interbank Offered Rate (EURIBOR), Swiss Average Rate Overnight (SARON), Tokyo Interbank Offered Rate (TIBOR), Bank Buying Rate (BBR) or base rates plus, in each case, an applicable margin between 1.50% to 1.125%, based on the total debt-to-EBITDA ratio and type of borrowing. Borrowings under the Term Loan Facility bear interest, at the Company's option, at SOFR or base rates plus, in each case, an applicable margin based on the total debt-to-EBITDA ratio. The Company has an uncommitted option to increase its Company Credit Facility by an additional \$500 million plus certain additional amounts based on its total debt-to-EBITDA ratio. The Term Loan Facility includes scheduled amortization payments equal to 0% for the first year following closing, 2.5% for the second year following closing and 5% thereafter until maturity.

The Company Credit Facility contains financial covenants including maintenance of a minimum fixed charge coverage ratio and a restriction on the Company's maximum total debt-to-EBITDA ratio not to exceed 4.0 to 1.0. It also contains certain non-financial covenants including: limitations on incurrence of additional indebtedness; restrictions on incurrence of liens; restrictions on dividends and other restricted payments; restrictions on investments, mergers, consolidations and asset sales; and limitations on transactions with affiliates. As of December 31, 2024, the Company was in compliance with all financial and non-financial covenants under the Company Credit Facility.

As of December 31, 2024, the Company had \$950 million of borrowings outstanding under the Revolving Credit Facility, with an interest rate of the base rate plus 0.25% margin, and \$2,006 million of borrowings outstanding under the Company's Term Loan Facility.

The Revolving Credit Facility and the Term Loan Facility will mature on August 16, 2026.

### ***Senior Note Debt Repurchase Program***

In June 2022, the Company's Board of Directors authorized a \$1,000 million senior note debt repurchase program in preparation for future debt reductions as part of the Company's strategic initiatives. No repurchases were made during the year ended December 31, 2024 and 2023. As of December 31, 2024, there was \$700 million available under the senior note debt repurchase program.

### ***Letters of Credit & Surety Bonds***

The Company had outstanding letters of credit of \$145 million as of December 31, 2024, which were not part of the Revolving Credit Facility. The letters of credit bore interest at 0.7% as of December 31, 2024. The Company had outstanding surety bonds of \$844 million as of December 31, 2024.

Aggregate maturities for the Company's debt for the years ending December 31, are as follows (\$ in millions):

	<b><u>Aggregate Maturities</u></b>	
2025	\$	110
2026		2,848
2027		2,405
2028		2,300
2029		3,277
Thereafter		7,700
Total	\$	<u>18,640</u>

The fair value of outstanding debt was approximately \$16,929 million and \$16,322 million at December 31, 2024 and 2023, respectively.

## 11. Leases

The Company records ROU assets and lease liabilities for non-cancelable operating leases primarily for real estate and equipment. Leases with an initial term of 12 months or less are not recorded on the balance sheet. Expense related to leases is recorded on a straight-line basis over the lease term, including rent holidays. The Company recognized operating lease expense of \$108 million and \$349 million during the years ended December 31, 2024 and 2023, respectively.

The Company considers the existence of options to extend or terminate leases in its analysis of the lease term for the purposes of measuring its ROU assets and lease liabilities. The renewal options are not included in the measurement of the ROU assets and lease liabilities unless the Company is reasonably certain to exercise the optional renewal periods.

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

	<u>December 31, 2024</u>	<u>December 31, 2023</u>
<b>Assets</b>		
ROU assets (recorded within other long-term assets)	\$ 359	\$ 396
<b>Liabilities</b>		
Short-term (recorded within accounts payable and accrued expenses)	\$ 158	\$ 168
Long-term (recorded within other long-term liabilities)	738	880
Total lease liabilities	<u>\$ 896</u>	<u>\$ 1,048</u>

Cash paid for amounts included in the measurement of lease liabilities, recorded as operating cash flows in the Consolidated Statements of Cash Flows, was \$227 million and \$378 million during the years ended December 31, 2024 and 2023, respectively. New operating leases commenced resulting in the recognition of ROU assets and lease liabilities of \$69 million and \$40 million during the years ended December 31, 2024 and 2023, respectively. As of December 31, 2024, the Company had additional operating leases that have not yet commenced of \$8 million. These operating leases will commence in 2025 with lease terms of approximately five years.

As part of the real estate optimization initiative as described in Note 6. *Property, Software and Equipment*, the Company vacated and abandoned various domestic leased properties. As a result, the Company assessed the ROU assets for impairment. The Company engaged a third-party real estate specialist to determine the recoverability of the leased properties. The valuation primarily considered comparable leased properties in each market and the assessment of potential future rental income that could be generated by the ROU assets.

As a result of the real estate optimization initiative, the Company recognized \$40 million and \$577 million of ROU asset impairments for the years ended December 31, 2023 and 2022, respectively. The remainder of the \$97 million and \$1,627 million real estate optimization impairment charges for the years ended December 31, 2023 and 2022, respectively, was related to Property, Software and Equipment, refer to Note 6. *Property, Software and Equipment*. No impairment charges related to this optimization occurred in 2024.

As of December 31, 2024, the weighted average remaining lease term for the Company was 7.5 years. The lease liabilities as of December 31, 2024, reflect a weighted average discount rate of 3.4%.

Lease payments over the next five years and thereafter are as follows (\$ in millions):

	<b>Lease Payments</b>	
2025	\$	185
2026		157
2027		134
2028		112
2029		98
Thereafter		334
Total lease payments		1,020
Less: imputed interest		(124)
Total lease liabilities	\$	896

## 12. Stockholders' Equity

The Company's Board of Directors has authorized a stock repurchase program of the Company's common stock from time to time on the open market or through privately negotiated transactions. In 2023, the Company's Board of Directors authorized an increase under the program of \$4,000 million. With these increases, the Company is authorized to repurchase up to \$10,000 million, inclusive of past authorizations. As of December 31, 2024, the Company had a remaining amount of \$2,230 million available under the Company's stock repurchase program. No duration has been placed on the repurchase program. The Company reserves the right to discontinue the repurchase program at any time.

Share repurchases in 2024, 2023 and 2022 were primarily funded through divestiture proceeds and free cash flow generated from operations. The following represents the Company's share repurchase activity (\$ in millions, shares in thousands):

	<b>Year Ended December 31,</b>					
	<b>2024</b>		<b>2023</b>		<b>2022<sup>(2)</sup></b>	
	<b>Shares</b>	<b>Cost</b>	<b>Shares</b>	<b>Cost</b>	<b>Shares</b>	<b>Cost</b>
Share buybacks	41,987	\$ 2,999	22,886	\$ 1,577	35,655	\$ 2,994
Income tax withholding	1,494	114	828	56	1,213	102
Total share repurchases <sup>(1)</sup>	43,481	\$ 3,113	23,714	\$ 1,633	36,868	\$ 3,096

<sup>(1)</sup> Excludes year-to-date share repurchase excise tax of approximately \$28 million and \$10 million accrued as of December 31, 2024 and 2023, respectively.

<sup>(2)</sup> Includes 11.6 million shares delivered as part of an accelerated share repurchase (ASR) agreement with a \$1,000 million notional amount. The Company purchased additional shares throughout the year through open market repurchases, including repurchase plans designed to comply with Rule 10b5-1.

Shares repurchased for income tax withholding are shares withheld in connection with employee stock plans to meet applicable tax withholding requirements. These shares are typically included in the Company's treasury stock.

## 13. Statutory Capital Requirements and Dividend Restrictions

Various state laws require Centene's regulated subsidiaries to maintain minimum capital levels specified by each state and restrict the amount of dividends that may be paid without prior regulatory approval. At December 31, 2024 and 2023, Centene's subsidiaries had aggregate statutory capital and surplus of \$20,258 million and \$18,117 million, respectively, compared with the required minimum aggregate statutory capital and surplus of \$9,083 million and \$8,267 million, respectively. As of December 31, 2024, the amount of capital and surplus or net worth that was unavailable for the payment of dividends or return of capital to the Company was \$9,083 million in the aggregate.

## 14. Income Taxes

The consolidated income tax expense consists of the following (\$ in millions):

	Year Ended December 31,		
	2024	2023	2022
<b>Income (loss) from continuing operations before income tax expense (benefit)</b>			
U.S. Federal	\$ 3,529	\$ 3,686	\$ 1,938
Foreign <sup>(1)</sup>	728	(88)	24
Total	\$ 4,257	\$ 3,598	\$ 1,962
<b>Income tax expense (benefit) from continuing operations</b>			
Current tax expense			
Federal	\$ 798	\$ 833	\$ 1,144
State and local	142	132	261
Foreign	—	1	4
Total current tax expense	\$ 940	\$ 966	\$ 1,409
Deferred tax expense (benefit)			
Federal	\$ 8	\$ (71)	\$ (514)
State and local	7	33	(126)
Foreign	8	(29)	(9)
Total deferred tax expense (benefit)	\$ 23	\$ (67)	\$ (649)
Total income tax expense (benefit)			
Federal	\$ 806	\$ 762	\$ 630
State and local	149	165	135
Foreign	8	(28)	(5)
Total income tax expense (benefit)	\$ 963	\$ 899	\$ 760

<sup>(1)</sup> Foreign income from continuing operations includes the Company's Cayman Islands reinsurance entity. The Company has elected for its Cayman Islands entity to be taxed as a U.S. corporation and pays U.S. tax at the 21% tax rate. The U.S. tax resulting from this entity is included in Federal income tax expense. This entity is expected to cease operating in 2025.

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

	Year Ended December 31,					
	2024		2023		2022	
	Total	%	Total	%	Total	%
Earnings from continuing operations, before income tax expense	\$ 4,257		\$ 3,598		\$ 1,962	
Tax provision at the U.S. federal statutory rate	894	21.0 %	756	21.0 %	412	21.0 %
Federal						
Effect of cross-border tax laws						
Global Intangible Low-Taxed Income (GILTI)	44	1.0 %	4	0.1 %	—	— %
Cayman Islands						
Statutory income tax rate differential <sup>(1)</sup>	142	3.3 %	62	1.7 %	6	0.3 %
Other	2	— %	(21)	(0.6)%	(1)	(0.1)%
Tax credits	(14)	(0.3)%	(5)	(0.1)%	(8)	(0.4)%
Changes in valuation allowances	(12)	(0.3)%	(2)	(0.1)%	(11)	(0.6)%
Nontaxable or nondeductible items						
Nondeductible compensation	37	0.9 %	29	0.8 %	51	2.6 %
Nondeductible goodwill	—	— %	—	— %	56	2.9 %
Nontaxable or nondeductible divestiture (gains) losses	(97)	(2.3)%	(9)	(0.3)%	79	4.0 %
Other nontaxable or nondeductible items	(1)	— %	(6)	(0.2)%	13	0.7 %
Other						
Deferred taxes for investments in subsidiaries	—	— %	—	— %	70	3.6 %
Excess tax benefit on stock awards	(3)	(0.1)%	(59)	(1.6)%	(13)	(0.7)%
Other	9	0.2 %	26	0.7 %	29	1.5 %
Foreign tax effects						
United Kingdom						
Nondeductible goodwill	(34)	(0.8)%	83	2.3 %	—	— %
Other	12	0.3 %	(26)	(0.7)%	(2)	(0.1)%
Cayman Islands						
Statutory income tax rate differential <sup>(1)</sup>	(142)	(3.3)%	(62)	(1.7)%	(6)	(0.3)%
Other jurisdictions	7	0.2 %	(16)	(0.4)%	—	— %
Changes in unrecognized tax benefits	24	0.6 %	27	0.8 %	13	0.7 %
State income taxes, net of federal income tax benefit <sup>(2)</sup>	95	2.2 %	118	3.3 %	72	3.7 %
Income tax expense	\$ 963	22.6 %	\$ 899	25.0 %	\$ 760	38.7 %

<sup>(1)</sup> The Company has elected for its Cayman Islands reinsurance entity to be taxed as a U.S. corporation and pays U.S. tax at the 21% tax rate. The taxability of this entity does not represent a reconciling item between the U.S. federal rate and the Company's effective tax rate. This entity ceased to operate in 2025.

<sup>(2)</sup> During the year ended December 31, 2024, state taxes in California, Florida and Illinois comprised greater than 50% of the tax effect in this category. During the year ended December 31, 2023, state taxes in California and Florida comprised greater than 50% of the tax effect in this category. During the year ended December 31, 2022, state taxes in California and Pennsylvania comprised greater than 50% of the tax effect in this category.

Income taxes paid are as follows (\$ in millions):

	Year Ended December 31,		
	2024	2023	2022
U.S. Federal <sup>(1)</sup>	\$ 930	\$ 698	\$ 1,009
Pennsylvania	*	53	*
Other <sup>(2)</sup>	71	138	175
Total U.S. State and Local	71	191	175
Foreign	1	(2)	14
Total income taxes paid, net	<u>\$ 1,002</u>	<u>\$ 887</u>	<u>\$ 1,198</u>

<sup>(1)</sup> Includes amounts paid to purchase transferable tax credits of \$100 million and \$49 million during the years ended December 31, 2024 and 2023, respectively.

<sup>(2)</sup> Includes amounts paid to purchase transferable tax credits of \$15 million, \$10 million and \$19 million during the years ended December 31, 2024, 2023 and 2022, respectively.

\* The amount of income taxes paid during the years ended December 31, 2024 and 2022 does not meet the 5% disaggregation threshold.

The tax effects of temporary differences which give rise to deferred tax assets and liabilities are presented below (\$ in millions):

	December 31, 2024	December 31, 2023
Deferred tax assets:		
Medical claims liability	\$ 178	\$ 217
Nondeductible liabilities	81	111
Net operating loss and tax credit carryforwards	70	71
Compensation accruals	93	113
Premium and trade receivables	72	94
Operating lease liability	231	269
Unrealized gain/loss	153	179
Software development costs	246	193
Other	92	92
Deferred tax assets	<u>1,216</u>	<u>1,339</u>
Valuation allowance	(77)	(82)
Net deferred tax assets	<u>\$ 1,139</u>	<u>\$ 1,257</u>
Deferred tax liabilities:		
Goodwill and intangible assets	\$ 1,518	\$ 1,603
Fixed assets	135	127
Right-of-use asset	88	98
Other	82	70
Deferred tax liabilities	<u>1,823</u>	<u>1,898</u>
Net deferred tax liabilities	<u>\$ (684)</u>	<u>\$ (641)</u>

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal and state net operating loss, federal and state capital loss and tax credit carryforwards.

Federal net operating loss and credit carryforwards of \$11 million expire beginning in 2025 through 2042. State net operating loss and tax credit carryforwards of \$42 million expire beginning in 2025 through 2043, while the remaining \$16 million have indefinite carryforward periods.

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

	<b>Year Ended December 31,</b>	
	<b>2024</b>	<b>2023</b>
Gross unrecognized tax benefits, January 1	\$ 439	\$ 410
Gross increases:		
Current year tax positions	16	19
Prior year tax positions	31	29
Gross decreases:		
Settlements <sup>(1)</sup>	(133)	(2)
Prior year tax positions	(6)	(10)
Statute of limitation lapses	(7)	(7)
Gross unrecognized tax benefits, December 31	<u>\$ 340</u>	<u>\$ 439</u>

<sup>(1)</sup> Primarily reflects the resolution of an item that had no net impact on the Consolidated Statement of Operations.

As of December 31, 2024, \$213 million of unrecognized tax benefits would impact the Company's effective tax rate in future periods, if recognized.

The table above excludes interest and penalties, net of related tax benefits, which are treated as income tax expense (benefit) under the Company's accounting policy. The Company recognized net interest expense and penalties related to uncertain positions of \$13 million and \$18 million for the years ended December 31, 2024 and 2023, respectively. The Company had \$98 million and \$84 million of accrued interest and penalties for uncertain tax positions as of December 31, 2024 and 2023, respectively.

The Company files federal tax returns as well as returns for numerous state tax jurisdictions and is engaged in multiple audit proceedings for its state filings. Generally, no further state audit activity is expected for years prior to 2015. As of December 31, 2024, the Company is not under federal examination.

## 15. Stock Incentive Plans

The Company's stock incentive plans allow for the granting of restricted stock or restricted stock unit awards and options to purchase common stock. Both incentive stock options and nonqualified stock options can be awarded under the plans. However, an immaterial amount of options were granted, exercised or outstanding in 2024. The plans have 10 million shares available for future awards.

Compensation expense for stock options and restricted stock unit awards is recognized on a straight-line basis over the vesting period, generally three to five years for stock options and one to three years for restricted stock or restricted stock unit awards. Vesting is accelerated by one year for individuals who qualify under the Company's retirement eligible provisions. Certain restricted stock unit awards contain performance-based or market-based provisions as well as service-based provisions. The fair value of restricted stock and restricted stock units with only service-based or performance-based provisions is determined using the previous day's market close price at the time of grant. The fair value of restricted stock units with market-based provisions is determined using a Monte Carlo simulation model. The fair value of stock options is determined based on the Black-Scholes option-pricing model. Forfeitures for all stock awards are recognized as they occur. The total compensation cost that has been charged against income for the stock incentive plans was \$212 million, \$216 million and \$234 million for the years ended December 31, 2024, 2023 and 2022, respectively. The total income tax benefit recognized in the Statements of Operations for stock-based compensation arrangements was \$26 million, \$101 million and \$48 million for the years ended December 31, 2024, 2023 and 2022, respectively.

A summary of the Company's non-vested restricted stock and restricted stock unit shares as of December 31, 2024, and changes during the year ended December 31, 2024, is presented below (shares in thousands):

	Shares	Weighted Average Grant Date Fair Value
Non-vested balance, December 31, 2023	7,462	\$ 68.96
Granted	3,741	76.84
Vested	(4,196)	69.42
Forfeited	(655)	70.88
Non-vested balance, December 31, 2024	6,352	\$ 73.10

The total fair value of restricted stock and restricted stock units vested during the years ended December 31, 2024, 2023 and 2022, was \$317 million, \$185 million and \$298 million, respectively.

As of December 31, 2024, there was \$223 million of total unrecognized compensation cost related to non-vested share-based compensation arrangements granted under the plans; that cost is expected to be recognized over a weighted-average period of 1.9 years.

The Company maintains an employee stock purchase plan and issued 572 thousand shares, 607 thousand shares and 449 thousand shares in 2024, 2023 and 2022, respectively.

## 16. Retirement Plan

Centene has a defined contribution plan which covers substantially all team members who are at least 21 years of age. Under the plan, eligible team members may contribute a percentage of their base salary, subject to certain limitations. Centene may elect to match a portion of the employee's contribution. Company expense related to matching contributions to the plan was \$136 million, \$131 million and \$133 million during the years ended December 31, 2024, 2023 and 2022, respectively.

## 17. Contingencies

The Company is routinely subjected to legal and regulatory proceedings in the normal course of business. These matters can include, without limitation:

- periodic compliance and other reviews and investigations by various federal and state regulatory agencies with respect to requirements applicable to the Company's business, which could result in litigation, including, without limitation, those related to payment of out-of-network claims, compliance with CMS Medicare and Marketplace regulations, including risk adjustment and broker compensation, compliance with the False Claims Act, the calculation of minimum MLR and rebates related thereto, submissions to state agencies related to payments or state false claims acts, pre-authorization penalties, timely review of grievances and appeals, timely and accurate payment of claims, provider directory accuracy, cybersecurity issues, including those related to the Company's or the Company's third-party vendors' information systems, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal and state fraud, waste and abuse laws;
- litigation arising out of regulatory proceedings and general business activities, such as tax matters, disputes related to healthcare benefits coverage or reimbursement, putative securities class actions, and medical malpractice, privacy, real estate, intellectual property, vendor disputes and employment-related claims; and
- disputes regarding reinsurance arrangements, claims arising out of the acquisition or divestiture of various assets, class actions, and claims relating to the performance of contractual and non-contractual obligations to providers, members, employer groups, third-party vendors and others, including, but not limited to, the alleged failure to properly pay claims and challenges to the manner in which the Company processes claims, claims related to network adequacy, provider directory accuracy and claims alleging that the Company has engaged in unfair business practices.

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

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

As of the date of this report, amounts accrued for legal proceedings and regulatory matters were not material. It is possible that in a particular quarter or annual period the Company's financial condition, results of operations, cash flow, and/or liquidity could be materially adversely affected by an ultimate unfavorable resolution of or development in legal and/or regulatory proceedings. The Company believes that the ultimate outcome of any of the regulatory and legal proceedings that are currently pending against it should not have a material adverse effect on financial condition, results of operations, cash flow, or liquidity.

## 18. Earnings Per Share

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

	Year Ended December 31,		
	2024	2023	2022
Earnings attributable to Centene Corporation	\$ 3,305	\$ 2,702	\$ 1,202
Shares used in computing per share amounts:			
Weighted average number of common shares outstanding	521,790	543,319	575,191
Common stock equivalents (as determined by applying the treasury stock method)	1,954	2,385	6,849
Weighted average number of common shares and potential dilutive common shares outstanding	<u>523,744</u>	<u>545,704</u>	<u>582,040</u>
Net earnings per common share attributable to Centene Corporation:			
Basic earnings per common share	\$ 6.33	\$ 4.97	\$ 2.09
Diluted earnings per common share	\$ 6.31	\$ 4.95	\$ 2.07

The calculation of diluted earnings per common share for 2024, 2023 and 2022 excludes the impact of 278 thousand shares, 376 thousand shares and 187 thousand shares, respectively, related to anti-dilutive stock options and restricted stock units.

## 19. Segment Information

The Company operates in four segments: (1) a Medicaid segment, (2) a Medicare segment, (3) a Commercial segment and (4) an Other segment. The Medicaid, Medicare and Commercial segments primarily represent the government-sponsored or subsidized programs under which the Company offers managed healthcare services. The Other segment includes the Company's pharmacy operations, Envolve Benefit Options' vision and dental services, clinical healthcare, behavioral health, international operations and corporate management company, among others. The Company's international businesses, Operose Health and Circle Health, which were included in the Other segment, were divested in December 2023 and January 2024, respectively.

Factors used in determining the reportable business segments include the nature of operating activities, the existence of separate senior management teams and the type of information presented to the Company's chief operating decision-maker (CODM) to evaluate all results of operations. The Company's CODM is its Chief Executive Officer. The Company's CODM focuses primarily on each segment's ability to generate sufficient revenues and manage expenses associated with health benefits and cost of services (including estimated costs incurred). As such, the CODM measures operating performance at the segment level based on gross margin, including evaluation of budget to actual variances, to determine the allocation of financial and capital resources for each segment. The Company does not report total assets by segment since this is not a metric used by the Company's CODM to allocate resources or evaluate segment performance.

Segment information for the year ended December 31, 2024, is as follows (\$ in millions):

	<u>Medicaid</u>	<u>Medicare</u>	<u>Commercial</u>	<u>Other/Eliminations</u>	<u>Consolidated Total</u>
Premium	\$ 83,758	\$ 23,032	\$ 33,699	\$ 1,814	\$ 142,303
Service	93	—	3	3,106	3,202
Premium and service revenues	83,851	23,032	33,702	4,920	145,505
Premium tax	17,566	—	—	—	17,566
Total external revenues	101,417	23,032	33,702	4,920	163,071
Internal revenues	—	—	—	16,879	16,879
Eliminations	—	—	—	(16,879)	(16,879)
Total revenues	<u>\$ 101,417</u>	<u>\$ 23,032</u>	<u>\$ 33,702</u>	<u>\$ 4,920</u>	<u>\$ 163,071</u>
Medical costs	\$ 77,516	\$ 20,437	\$ 26,039	\$ 1,715	\$ 125,707
Cost of services	89	—	—	2,640	2,729
Other operating expenses <sup>(1)</sup>					31,460
Other income (expense) <sup>(2)</sup>					1,082
Earnings before income tax expense					<u>\$ 4,257</u>
Segment gross margin <sup>(3)</sup>	\$ 6,246	\$ 2,595	\$ 7,663	\$ 565	\$ 17,069

<sup>(1)</sup> Other operating expenses include selling, general and administrative expenses, depreciation, amortization, premium tax expense and impairment.

<sup>(2)</sup> Other income (expense) includes investment and other income, debt extinguishment and interest expense.

<sup>(3)</sup> Segment gross margin represents premium and service revenues less medical costs and cost of services.

Segment information for the year ended December 31, 2023, is as follows (\$ in millions):

	Medicaid	Medicare	Commercial	Other/Eliminations	Consolidated Total
Premium	\$ 86,853	\$ 22,261	\$ 24,843	\$ 1,679	\$ 135,636
Service	2	—	2	4,455	4,459
Premium and service revenues	86,855	22,261	24,845	6,134	140,095
Premium tax	13,904	—	—	—	13,904
Total external revenues	100,759	22,261	24,845	6,134	153,999
Internal revenues	—	—	—	16,735	16,735
Eliminations	—	—	—	(16,735)	(16,735)
Total revenues	\$ 100,759	\$ 22,261	\$ 24,845	\$ 6,134	\$ 153,999
Medical costs	\$ 78,210	\$ 19,394	\$ 19,816	\$ 1,474	\$ 118,894
Cost of services	4	—	—	3,560	3,564
Other operating expenses <sup>(1)</sup>					28,611
Other income (expense) <sup>(2)</sup>					668
Earnings before income tax expense					\$ 3,598
Segment gross margin <sup>(3)</sup>	\$ 8,641	\$ 2,867	\$ 5,029	\$ 1,100	\$ 17,637

<sup>(1)</sup> Other operating expenses include selling, general and administrative expenses, depreciation, amortization, premium tax expense and impairment.

<sup>(2)</sup> Other income (expense) includes investment and other income, debt extinguishment and interest expense.

<sup>(3)</sup> Segment gross margin represents premium and service revenues less medical costs and cost of services.

Segment information for the year ended December 31, 2022, is as follows (\$ in millions):

	Medicaid	Medicare	Commercial	Other/Eliminations	Consolidated Total
Premium	\$ 84,084	\$ 22,484	\$ 17,377	\$ 3,186	\$ 127,131
Service	(1)	—	3	8,346	8,348
Premium and service revenues	84,083	22,484	17,380	11,532	135,479
Premium tax	9,068	—	—	—	9,068
Total external revenues	93,151	22,484	17,380	11,532	144,547
Internal revenues	—	—	—	25,191	25,191
Eliminations	—	—	—	(25,191)	(25,191)
Total revenues	\$ 93,151	\$ 22,484	\$ 17,380	\$ 11,532	\$ 144,547
Medical costs	\$ 75,298	\$ 19,372	\$ 14,092	\$ 2,767	\$ 111,529
Cost of services	—	—	—	7,032	7,032
Other operating expenses <sup>(1)</sup>					24,668
Other income (expense) <sup>(2)</sup>					644
Earnings before income tax expense					\$ 1,962
Segment gross margin <sup>(3)</sup>	\$ 8,785	\$ 3,112	\$ 3,288	\$ 1,733	\$ 16,918

<sup>(1)</sup> Other operating expenses include selling, general and administrative expenses, depreciation, amortization, premium tax expense and impairment.

<sup>(2)</sup> Other income (expense) includes investment and other income, debt extinguishment and interest expense.

<sup>(3)</sup> Segment gross margin represents premium and service revenues less medical costs and cost of services.

**20. Condensed Financial Information of Registrant**

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

	<u>December 31, 2024</u>	<u>December 31, 2023</u>
<b>ASSETS</b>		
Current assets:		
Cash and cash equivalents	\$ 7	\$ 7
Other current assets	9	7
Total current assets	16	14
Long-term investments	206	264
Investment in subsidiaries	45,148	43,853
Other long-term assets	85	186
Total assets	<u>\$ 45,455</u>	<u>\$ 44,317</u>
<b>LIABILITIES, REDEEMABLE NONCONTROLLING INTERESTS AND STOCKHOLDERS' EQUITY</b>		
Current liabilities:		
Current liabilities	\$ 243	\$ 417
Current portion of long-term debt	110	110
Total current liabilities	353	527
Long-term debt	18,423	17,708
Other long-term liabilities	169	126
Total liabilities	18,945	18,361
Commitments and contingencies		
Redeemable noncontrolling interest	10	19
Stockholders' equity:		
Preferred stock, \$0.001 par value; authorized 10,000 shares; no shares issued or outstanding at December 31, 2024 and December 31, 2023	—	—
Common stock, \$0.001 par value; authorized 800,000 shares; 620,195 issued and 495,907 outstanding at December 31, 2024, and 615,291 issued and 534,484 outstanding at December 31, 2023	1	1
Additional paid-in capital	20,562	20,304
Accumulated other comprehensive (loss)	(504)	(652)
Retained earnings	15,348	12,043
Treasury stock, at cost (124,288 and 80,807 shares, respectively)	(8,997)	(5,856)
Total Centene stockholders' equity	26,410	25,840
Nonredeemable noncontrolling interest	90	97
Total stockholders' equity	26,500	25,937
Total liabilities, redeemable noncontrolling interests and stockholders' equity	<u>\$ 45,455</u>	<u>\$ 44,317</u>

See notes to condensed financial information of registrant.

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

	Year Ended December 31,		
	2024	2023	2022
<b>Expenses:</b>			
Selling, general and administrative expenses	\$ 13	\$ 14	\$ 21
Legal settlement	—	—	33
<b>Other income (expense):</b>			
Investment and other income	(34)	(47)	55
Gain (loss) on divestiture	(34)	108	13
Debt extinguishment	—	—	14
Interest expense	(700)	(710)	(643)
<b>(Loss) before income taxes</b>	<b>(781)</b>	<b>(663)</b>	<b>(615)</b>
Income tax (benefit)	(76)	(118)	(208)
<b>Net (loss) before equity in subsidiaries</b>	<b>(705)</b>	<b>(545)</b>	<b>(407)</b>
Equity in earnings from subsidiaries	3,999	3,244	1,609
<b>Net earnings</b>	<b>3,294</b>	<b>2,699</b>	<b>1,202</b>
Loss attributable to noncontrolling interests	11	3	—
<b>Net earnings attributable to Centene Corporation</b>	<b>\$ 3,305</b>	<b>\$ 2,702</b>	<b>\$ 1,202</b>
<b>Net earnings per common share attributable to Centene Corporation:</b>			
Basic earnings per common share	\$ 6.33	\$ 4.97	\$ 2.09
Diluted earnings per common share	\$ 6.31	\$ 4.95	\$ 2.07

See notes to condensed financial information of registrant.

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

	<b>Year Ended December 31,</b>		
	<b>2024</b>	<b>2023</b>	<b>2022</b>
<b>Cash flows from operating activities:</b>			
Dividends from subsidiaries, return on investment	\$ 1,797	\$ 2,823	\$ 1,706
Payments for legal settlement	(263)	(326)	(282)
Other operating activities, net	(422)	(334)	(450)
Net cash provided by operating activities	<u>1,112</u>	<u>2,163</u>	<u>974</u>
<b>Cash flows from investing activities:</b>			
Capital contributions to subsidiaries	(730)	(443)	(880)
Purchases of investments	(2)	(202)	(2)
Dividends from subsidiaries, return of investment	321	85	10
Investments in acquisitions	—	—	(2,431)
Proceeds from divestitures	—	325	—
Intercompany activities	1,693	(357)	5,785
Other investing activities, net	—	—	3
Net cash (used in) provided by investing activities	<u>1,282</u>	<u>(592)</u>	<u>2,485</u>
<b>Cash flows from financing activities:</b>			
Proceeds from common stock issuances	46	44	70
Proceeds from long-term debt	1,300	2,305	75
Payments and repurchases of long-term debt	(610)	(2,290)	(491)
Common stock repurchases	(3,124)	(1,633)	(3,096)
Payments for debt extinguishment	—	—	(14)
Other financing activities, net	(6)	(2)	—
Net cash used in financing activities	<u>(2,394)</u>	<u>(1,576)</u>	<u>(3,456)</u>
Net increase (decrease) in cash and cash equivalents	<u>—</u>	<u>(5)</u>	<u>3</u>
<b>Cash and cash equivalents, beginning of period</b>	<u>7</u>	<u>12</u>	<u>9</u>
<b>Cash and cash equivalents, end of period</b>	<u>\$ 7</u>	<u>\$ 7</u>	<u>\$ 12</u>

See notes to condensed financial information of registrant.

## Notes to Condensed Financial Information of Registrant

### Note A - Basis of Presentation and Significant Accounting Policies

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

The parent company's investment in subsidiaries is stated at cost plus equity in undistributed earnings of the subsidiaries. The parent company's share of net income of its unconsolidated subsidiaries is included in income using the equity method of accounting. Certain unrestricted subsidiaries receive monthly management fees from the Company's restricted subsidiaries. The management and service fees received by its unrestricted subsidiaries are associated with all of the functions required to manage the restricted subsidiaries including, but not limited to, salaries and wages for personnel, rent, utilities, population health management, provider contracting, compliance, member services, claims processing, information technology, cash management, finance and accounting and other services. Beginning in 2023, the management fees are based on a cost basis reimbursement.

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

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

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

None.

### Item 9A. Controls and Procedures

**Evaluation of Disclosure Controls and Procedures** - Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, evaluated the effectiveness of our disclosure controls and procedures as of December 31, 2024. The term "disclosure controls and procedures," as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act, means controls and other procedures of a company that are designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the company's management, including its principal executive and principal financial officers, as appropriate to allow timely decisions regarding required disclosure. Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving their objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Based on the evaluation of our disclosure controls and procedures as of December 31, 2024, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective.

**Management's Report on Internal Control Over Financial Reporting** - Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f) and 15d-15(f). Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on our evaluation under the framework in *Internal Control - Integrated Framework (2013)*, our management concluded that our internal control over financial reporting was effective at the reasonable assurance level as of December 31, 2024. Our management's assessment of the effectiveness of our internal control over financial reporting as of December 31, 2024, has been audited by KPMG LLP, an independent registered public accounting firm, as stated in their report which is included herein.

**Changes in Internal Control Over Financial Reporting** - No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the year ended December 31, 2024 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

## Report of Independent Registered Public Accounting Firm

To the Stockholders and Board of Directors  
Centene Corporation:

### *Opinion on Internal Control Over Financial Reporting*

We have audited Centene Corporation and subsidiaries' (the Company) internal control over financial reporting as of December 31, 2024, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2024, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of the Company as of December 31, 2024 and 2023, the related consolidated statements of operations, comprehensive earnings (loss), stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2024, and the related notes (collectively, the consolidated financial statements), and our report dated February 18, 2025 expressed an unqualified opinion on those consolidated financial statements.

### *Basis for Opinion*

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

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

### *Definition and Limitations of Internal Control Over Financial Reporting*

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

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

/s/ KPMG LLP

St. Louis, Missouri  
February 18, 2025

**Item 9B. Other Information**

(a) None.

(b) During the three months ended December 31, 2024, no director or officer of the Company adopted or terminated a "Rule 10b5-1 trading arrangement" or "non-Rule 10b5-1 trading arrangement," as each term is defined in Item 408(a) of Regulation S-K.

**Item 9C. Disclosure Regarding Foreign Jurisdictions that Prevent Inspections**

Not applicable

**PART III**

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

**(a) Directors of the Registrant**

Information concerning our directors will appear in our Proxy Statement for our 2025 annual meeting of stockholders under "Proposal One: Election of Directors." This portion of the Proxy Statement is incorporated herein by reference.

**(b) Information about our Executive Officers**

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

Information concerning our executive officers' compliance with Section 16(a) of the Exchange Act will appear in our Proxy Statement for our 2025 annual meeting of stockholders under "Delinquent Section 16(a) Reports," if applicable.

**(c) Corporate Governance**

Information concerning certain corporate governance matters, including information concerning our audit committee financial expert and identification of our Audit and Compliance Committee, and our code of ethics will appear in our Proxy Statement for our 2025 annual meeting of stockholders under "Corporate Governance." These portions of our Proxy Statement are incorporated herein by reference.

**(d) Insider Trading Policies and Procedures**

The Company has adopted the Policy on Inside Information and Insider Trading attached as Exhibit 19.1 hereto, which governs the purchase, sale, and/or other dispositions of the Company's securities by directors, officers and employees, and by the Company itself, and is reasonably designed to promote compliance with insider trading laws, rules and regulations, and the NYSE listing standards.

**Item 11. Executive Compensation**

Information concerning executive compensation will appear in our Proxy Statement for our 2025 Annual Meeting of Stockholders under "Executive Compensation." Information concerning Compensation and Talent Committee interlocks and insider participation will appear in the Proxy Statement for our 2025 Annual Meeting of Stockholders under "Compensation & Talent Committee Interlocks and Insider Participation." These portions of the Proxy Statement are incorporated herein by reference.

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

Information concerning the security ownership of certain beneficial owners and management and our equity compensation plans will appear in our Proxy Statement for our 2025 annual meeting of stockholders under "Security Ownership of Certain Beneficial Owners and Management" and "Equity Compensation Plan Information." These portions of the Proxy Statement are incorporated herein by reference.

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

Information concerning director independence, certain relationships and related transactions will appear in our Proxy Statement for our 2025 annual meeting of stockholders under "Corporate Governance," "Independence of Directors" and "Related Party Transactions." These portions of our Proxy Statement are incorporated herein by reference.

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

Our independent registered public accounting firm is KPMG LLP, St. Louis, MO. The Auditor Firm ID is 185.

Information concerning principal accountant fees and services will appear in our Proxy Statement for our 2025 annual meeting of stockholders under "Proposal Three: Ratification of Appointment of Independent Registered Public Accounting Firm." This portion of our Proxy Statement is incorporated herein by reference.

## **PART IV**

### **Item 15. Exhibits and Financial Statement Schedules**

#### **(a) Financial Statements and Schedules**

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

1. Financial Statements:

Report of Independent Registered Public Accounting Firm  
Consolidated Balance Sheets as of December 31, 2024 and 2023  
Consolidated Statements of Operations for the years ended December 31, 2024, 2023 and 2022  
Consolidated Statements of Comprehensive Earnings (Loss) for the years ended December 31, 2024, 2023 and 2022  
Consolidated Statements of Stockholders' Equity for the years ended December 31, 2024, 2023 and 2022  
Consolidated Statements of Cash Flows for the years ended December 31, 2024, 2023 and 2022  
Notes to Consolidated Financial Statements

2. Financial Statement Schedules:

None.

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

**EXHIBIT INDEX**

EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE		
			FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
3.1	<a href="#">Amended and Restated Certificate of Incorporation of Centene Corporation, dated September 27, 2022</a>		8-K	September 30, 2022	3.1
3.2	<a href="#">Amended and Restated By-laws of Centene Corporation, dated December 8, 2023</a>		8-K	December 13, 2023	3.1
4.1	<a href="#">Description of Securities of the Company</a>		S-3ASR	February 21, 2024	
4.2	<a href="#">Indenture, dated as of December 6, 2019, by and between Centene Corporation, as issuer, and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to the Company's 4.25% Senior Notes due 2027 (including the Form of Global Note attached thereto)</a>		8-K	December 6, 2019	4.2
4.3	<a href="#">Indenture, dated as of December 6, 2019, by and between Centene Corporation, as issuer, and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to the Company's 4.625% Senior Notes due 2029 (including the Form of Global Note attached thereto)</a>		8-K	December 6, 2019	4.3
4.4	<a href="#">Indenture, dated as of February 13, 2020, by and between Centene Corporation, as issuer, and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to the Company's 3.375% Senior Notes due 2030 (including the Form of Global Note attached thereto)</a>		8-K	February 13, 2020	4.1
4.5	<a href="#">Base Indenture, dated as of October 7, 2020, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee</a>		8-K	October 7, 2020	4.1
4.6	<a href="#">First Supplemental Indenture, dated as of October 7, 2020, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee</a>		8-K	October 7, 2020	4.2
4.7	<a href="#">Second Supplemental Indenture, dated as of February 17, 2021, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee</a>		8-K	February 17, 2021	4.2
4.8	<a href="#">Third Supplemental Indenture, dated as of July 1, 2021, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee</a>		8-K	July 1, 2021	4.2
4.9	<a href="#">Fourth Supplemental Indenture, dated as of August 12, 2021, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee</a>		8-K	August 12, 2021	4.4
10.1	* <a href="#">2002 Employee Stock Purchase Plan, As Amended and Restated</a>		10-Q	July 23, 2019	10.1
10.2	* <a href="#">Amendment No.1 to the 2002 Employee Stock Purchase Plan, As Amended and Restated</a>		S-8	May 22, 2020	4.2
10.3	* <a href="#">Centene Corporation 2012 Stock Incentive Plan, as amended</a>		8-K	April 30, 2021	10.1
10.4	* <a href="#">Amended and Restated Non-Employee Directors Deferred Stock Compensation Plan</a>		10-Q	July 26, 2024	10.1
10.5	* <a href="#">Amended and Restated Voluntary Nonqualified Deferred Compensation Plan</a>		10-K	February 20, 2024	10.5
10.6	* <a href="#">Centene Corporation 2007 Long-Term Incentive Plan, as Amended</a>		10-K	February 22, 2021	10.6
10.7	* <a href="#">Centene Corporation Short-Term Executive Compensation Plan</a>		10-K	February 22, 2011	10.12

10.8	*	<a href="#">Executive Severance and Change in Control Plan</a>		10-Q	October 25, 2024	10.1
10.9	*	<a href="#">Form of Non-Employee Director Compensation Policy</a>	X			
10.10	*	<a href="#">Form of Non-Employee Director Restricted Stock Unit Agreement #1</a>		10-Q	July 26, 2024	10.2
10.11	*	<a href="#">Form of Non-statutory Stock Option Agreement (Employees) #1</a>		10-K	February 22, 2021	10.11
10.12	*	<a href="#">Form of Non-statutory Stock Option Agreement (Employees) #2</a>		10-K	February 22, 2022	10.12
10.13	*	<a href="#">Form of Non-statutory Stock Option Agreement (Directors)</a>		10-K	February 21, 2023	10.13
10.14	*	<a href="#">Form of Restricted Stock Agreement (Directors) #1</a>		10-K	February 21, 2023	10.14
10.15	*	<a href="#">Form of Restricted Stock Agreement (Directors) #2</a>		10-Q	July 28, 2023	10.1
10.16	*	<a href="#">Form of Restricted Stock Unit Agreement #1</a>		10-Q	April 26, 2024	10.1
10.17	*	<a href="#">Form of Restricted Stock Unit Agreement #2</a>		8-K	December 21, 2020	10.1
10.18	*	<a href="#">Form of Restricted Stock Unit Agreement #3</a>		10-Q	April 25, 2023	10.1
10.19	*	<a href="#">Form of Restricted Stock Unit Agreement #4</a>		10-Q	April 25, 2023	10.2
10.20	*	<a href="#">Form of Performance Based Restricted Stock Unit Agreement #1</a>		10-Q	April 26, 2024	10.2
10.21	*	<a href="#">Form of Performance Based Restricted Stock Unit Agreement #2</a>		8-K	December 21, 2020	10.2
10.22	*	<a href="#">Form of Performance Based Restricted Stock Unit Agreement #3</a>		10-Q	April 25, 2023	10.3
10.23	*	<a href="#">Form of Long-Term Incentive Plan Agreement</a>		8-K	December 21, 2020	10.3
10.24		<a href="#">Fourth Amended and Restated Credit Agreement, dated as of August 16, 2021, among the Company, Wells Fargo Bank, National Association, as administrative agent, and the lenders and other parties thereto</a>		8-K	August 18, 2021	1.1
10.24a		<a href="#">First Amendment to the Fourth Amended and Restated Credit Agreement, dated as of May 31, 2023, by and among Centene Corporation, the several banks and other financial institutions party thereto, and Wells Fargo Bank, National Association, as the administrative agent.</a>		8-K	June 6, 2023	10.1
10.25	*	<a href="#">Executive Employment Agreement between Centene Corporation and Sarah M. London, dated April 27, 2022</a>		10-Q	July 26, 2022	10.1
10.25a	*	<a href="#">Amendment of Executive Employment Agreement between Centene Corporation and Sarah M. London, dated February 20, 2023</a>		10-K	February 21, 2023	10.22a
10.26	*	<a href="#">Executive Employment Agreement between Centene Corporation and Andrew Asher, dated April 28, 2022</a>		10-Q	July 26, 2022	10.3
10.26a	*	<a href="#">Amendment of Executive Employment Agreement between Centene Corporation and Andrew Asher, dated February 20, 2023</a>		10-K	February 21, 2023	10.23a
10.27	*	<a href="#">Executive Employment Agreement between Centene Corporation and Kenneth Fasola, dated February 20, 2023</a>		10-K	February 21, 2023	10.24
10.28	*	<a href="#">Executive Employment Agreement between Centene Corporation and James E. Murray, dated February 20, 2023</a>		10-K	February 21, 2023	10.25
10.29	*	<a href="#">Transition Services Agreement between Centene Corporation and Kenneth Burdick, dated February 21, 2020</a>		10-K	February 22, 2021	10.25

10.30	*	<a href="#">Executive Officer Cash Severance Policy</a>		10-K	February 21, 2023	10.31
10.31	*	<a href="#">Executive Restricted Covenant Agreement</a>		10-K	February 20, 2024	10.31
19.1		<a href="#">Policy on Inside Information and Insider Trading</a>	X			
21		<a href="#">List of subsidiaries</a>	X			
23		<a href="#">Consent of Independent Registered Public Accounting Firm incorporated by reference in each prospectus constituting part of the Registration Statements on Form S-8 (File Numbers 333-261993, 333-255735, 333-238597, 333-236036, 333-217634, 333-210376, 333-197737, 333-180976, and 333-90976) and Form S-3 (File Number 333-277218)</a>	X			
31.1		<a href="#">Certification Pursuant to Rule 13a-14(a) and 15d-14(a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Executive Officer)</a>	X			
31.2		<a href="#">Certification Pursuant to Rule 13a-14(a) and 15d-14(a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Financial Officer)</a>	X			
32.1	#	<a href="#">Certification Pursuant to 18 U.S.C. Section 1350 (Chief Executive Officer)</a>	X			
32.2	#	<a href="#">Certification Pursuant to 18 U.S.C. Section 1350 (Chief Financial Officer)</a>	X			
97	*	<a href="#">Centene Corporation Clawback Policy</a>		10-K	February 20, 2024	97
101		The following materials from the Centene Corporation Annual Report on Form 10-K for the fiscal year ended December 31, 2024, formatted in Inline Extensible Business Reporting Language (iXBRL): (i) the Consolidated Balance Sheets, (ii) the Consolidated Statements of Operations, (iii) the Consolidated Statements of Comprehensive Earnings (Loss), (iv) the Consolidated Statements of Stockholders' Equity, (v) the Consolidated Statements of Cash Flows and (vi) related notes.	X			
104		Cover Page Interactive Data File (embedded within the Inline XBRL document)	X			

\* Indicates a management contract or compensatory plan or arrangement.

# This certification is deemed not filed for purposes of Section 18 of the Exchange Act, or otherwise subject to the liability of that section, nor shall it be deemed incorporated by reference into any filing under the Securities Act of 1933, as amended, or the Exchange Act.

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

None.

**SIGNATURES**

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, as of February 18, 2025.

## CENTENE CORPORATION

By: /s/ SARAH M. LONDON  
**Sarah M. London**  
**Chief Executive Officer**

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities as indicated, as of February 18, 2025.

<b>Signature</b>	<b>Title</b>
<u>/s/ Sarah M. London</u> <b>Sarah M. London</b>	Chief Executive Officer (principal executive officer)
<u>/s/ Andrew L. Asher</u> <b>Andrew L. Asher</b>	Executive Vice President, Chief Financial Officer (principal financial officer)
<u>/s/ Katie N. Casso</u> <b>Katie N. Casso</b>	Senior Vice President, Finance, Corporate Controller and Chief Accounting Officer (principal accounting officer)
<u>/s/ Jessica L. Blume</u> <b>Jessica L. Blume</b>	Director
<u>/s/ Kenneth A. Burdick</u> <b>Kenneth A. Burdick</b>	Director
<u>/s/ Christopher J. Coughlin</u> <b>Christopher J. Coughlin</b>	Director
<u>/s/ H. James Dallas</u> <b>H. James Dallas</b>	Director
<u>/s/ Wayne S. DeVeydt</u> <b>Wayne S. DeVeydt</b>	Director
<u>/s/ Fred H. Eppinger</u> <b>Fred H. Eppinger</b>	Director
<u>/s/ Monte E. Ford</u> <b>Monte E. Ford</b>	Director
<u>/s/ Thomas R. Greco</u> <b>Thomas R. Greco</b>	Director
<u>/s/ Lori J. Robinson</u> <b>Lori J. Robinson</b>	Director
<u>/s/ Theodore R. Samuels</u> <b>Theodore R. Samuels</b>	Director

**CENTENE CORPORATION****Non-Employee Director Compensation Policy**

This Non-Employee Director Compensation Policy (the “Policy”) sets forth the compensation to be paid to non-employee members (“Non-Employee Directors”) of the Board of Directors (the “Board”) of Centene Corporation (the “Company”), which shall remain in effect until amended, replaced or rescinded by further action of the Board.

**Annual Retainers and Fees**

Effective January 1, 2024, the retainers and fees for Non-Employee Directors will be as set forth below and shall be cumulative.

**Board Service:**

- A base annual retainer of \$100,000.

**Independent Chair of the Board/Lead Independent Director –**

- The non-executive Chairman of the Board will be eligible to receive the \$100,000 annual retainer that all members of the Board receive, as well as the annual grant of restricted shares with a value of \$225,000 (discussed below), which vest annually at the annual shareholders’ meeting. In addition, the non-executive Chairman will also receive an additional grant of restricted stock units with a value of \$150,000, which vest annually at the annual shareholder’s meeting and may be deferred. The non-executive Chairman will also receive an additional cash retainer of \$90,000 per year.

**Standing Committees:**

- Audit and Compliance Committee – The Chair of the Audit and Compliance Committee shall receive an additional annual retainer of \$30,000.
- Compensation and Talent Committee – The Chair of the Compensation and Talent Committee shall receive an additional annual retainer of \$20,000.
- Governance Committee – The Chair of the Governance Committee shall receive an additional annual retainer of \$20,000.
- Quality Committee – The Chair of the Quality Committee shall receive an additional annual retainer of \$20,000.

**Payments**

The annual retainers for service on the Board and committees of the Board as set forth above shall be paid by the Company in quarterly installments as soon as practicable after the end of each of the Company’s fiscal quarters for which the member shall have served. A member of the Board or any of its committees who serves on such during a portion of a quarterly period, shall be entitled to the pro-rata portion of the quarterly installment based on the number of days the Non-Employee Director served as a Non-Employee Director during the quarterly period.

All fees payable to Non-Employee Directors are eligible for deferral under the Non-Employee Directors Deferred Stock Compensation Plan. The number of restricted stock units granted shall be determined by reference to the officially-quoted closing selling price of the Company’s common stock on the New York Stock Exchange on the trading day preceding the grant date.

### **Initial Equity Awards**

Unless otherwise determined by the Compensation and Talent Committee and subject to the Board of Director's approval, upon, and contingent on, a new Non-Employee Director's appointment to the Board, shall receive an initial equity award of restricted stock units with a fair market value of approximately \$225,000, pro-rated (based on a 365 day year) for the number of days between the appointment of the Non-Employee Director and the anticipated date of the next annual meeting of stockholders at the time of appointment or election as determined by the Secretary of the Company, rounded to the nearest whole share, as determined by reference to the officially-quoted closing selling price of the Company's common stock on the New York Stock Exchange on the day preceding the grant date, pursuant to and in accordance with the terms and provisions of a restricted stock unit agreement and the Company's 2012 Incentive Stock Plan (the "2012 Plan"). Such equity awards shall vest in full on the earlier of the first anniversary of the date of the grant or the date of the next annual meeting of stockholders.

### **Annual Equity Awards**

Unless otherwise determined by the Compensation and Talent Committee and subject to the Board of Directors' approval, each Non-Employee Director shall receive an annual equity award of restricted stock units, with a fair market value of approximately \$225,000, rounded to the nearest whole share, as determined by reference to the officially-quoted closing selling price of the Company's common stock on the New York Stock Exchange on the trading day immediately preceding the grant date, pursuant to and in accordance with the terms and provisions of a restricted stock unit agreement or deferred stock unit agreement, as the case may be, and the 2012 Plan. Unless otherwise determined by the Compensation Committee, all such annual equity awards shall be granted on the date of the Company's annual meeting of stockholders. Such equity awards shall vest in full on the earlier of the first anniversary of the date of the grant or the date of the next annual meeting of stockholders.

### **Charitable Matching Gift Program**

Under the Board of Directors Charitable Matching Gift Program, the Company will match a Non-Employee Director's qualifying charitable donation up to \$25,000 per calendar year. Charitable donations must be made to a qualified tax-exempt U.S. organization under the Internal Revenue Code Section 501(c)(3) and within the Company's charitable contribution guidelines.

### **Liability Insurance**

The Company shall provide a group excess liability insurance policy at no cost to the Non-Employee Directors.

### **Expenses**

Non-Employee Directors will be reimbursed for all reasonable expenses incurred in connection with their service on the Board.

### **Stock Ownership Guidelines**

Non-Employee Directors are required to own shares of the Company's common stock (the "Ownership Requirement") having a value (as described below) equal to the sum of seven and a half (7.5) times the base annual retainer payable to each Non-Employee Director as set forth in this Policy as in effect from time to time.

For purposes of determining ownership, the following will be used in determining whether a Non-Employee Director has satisfied the Ownership Requirement:

- One hundred percent (100%) of the value of shares of the Company's common stock owned individually, either directly or indirectly, including vested and unvested restricted stock, restricted stock unit awards, deferred stock unit awards or shares acquired upon exercise of stock options; and
- Shares of the Company's common stock owned jointly, or separately by a spouse, domestic partner and/or minor children, directly or indirectly.

No other rights to acquire shares of Company common stock (including stock options or similar rights) shall be considered shares of Company common stock for purposes of meeting the Ownership Requirements under this Policy.

For purposes hereof, the value of a share of the Company's common stock, including vested and unvested restricted stock, restricted stock units and deferred stock units, shall be calculated on September 30<sup>th</sup> of each year as determined by reference to the officially-quoted closing selling price of the Company's common stock on the New York Stock Exchange on previous date of the calculation (a "Determination Date"). If a Non-Employee Director does not meet the Ownership Requirement as of the Determination Date following the fifth anniversary of such Non-Employee Director's election or appointment to the Board, such Non-Employee Director is expected to satisfy the Ownership Requirement on the next Determination Date and is not allowed to sell shares until Ownership Requirements are met.

In the event the base annual retainer increases, each Non-Employee Director will have five (5) years from the time of the increase to acquire any additional shares needed to satisfy the Ownership Requirement.

A Non-Employee Director shall have until the end of the first Determination Date following the fifth anniversary of such Non-Employee Director's election or appointment to the Board or upon otherwise becoming a Non-Employee Director of the Board to satisfy the Ownership Requirement.

## CENTENE CORPORATION

Policy on Inside Information and Insider Trading**I. BACKGROUND/PURPOSE:**

Under federal and state securities laws, it is illegal to purchase or sell securities of a company while in possession of material, non-public information related to, affecting or regarding that company or its subsidiaries (such information, “Inside Information”), or to disclose Inside Information to others who then trade in company securities. Insider trading violations are pursued vigorously by the United States Securities and Exchange Commission (the “SEC”) and other governmental agencies and can result in severe penalties. While the regulatory authorities usually concentrate their efforts on the individuals who trade, or who tip material, non-public information to others who trade, the federal securities laws also impose potential liability on companies and other “controlling persons” if they fail to take reasonable steps to prevent insider trading by company personnel.

Centene Corporation (“Centene”) has adopted this Policy on Inside Information and Insider Trading (this “Policy”) both to facilitate satisfaction of Centene’s obligation to prevent insider trading and to help Centene personnel avoid violating insider trading laws.

**II. APPLICABILITY OF POLICY****A. Covered Persons**

This Policy applies to all employees of Centene and its subsidiaries, all members of the Board of Directors of Centene and the boards of directors of Centene’s subsidiaries (collectively, “directors”), consultants, contractors and any persons (including, but not limited to family members) that reside in the same household as any of the foregoing persons as provided herein. This Policy also applies to any person, partnership, trust or other entity or account whose securities trading decisions are influenced or controlled by any of the foregoing persons. The failure of any person subject to this Policy to observe and strictly adhere to the policies and procedures set forth herein at all times will be grounds for disciplinary action, up to and including termination of employment.

**B. Covered Transactions**

This Policy applies to all transactions in Centene’s securities, including common stock and any securities that are exercisable for, or convertible or exchangeable into, common stock, and any other securities Centene may issue from time to time whether or not pursuant to any benefit plan adopted by Centene except as provided below.

**Rule 10b5-1 Plans.** Rule 10b5-1 under the Securities Exchange Act of 1934, as amended (the “Exchange Act”), provides an affirmative defense from insider trading liability under the federal securities laws for written trading plans that meet certain requirements (“10b5-1 plans”). You must act in good faith with respect to a 10b5-1 plan when the plan is adopted and for the duration of the plan, and must not enter into a 10b5-1 plan as part of a plan or scheme to evade the prohibitions of Exchange Act Rule 10b-5. A 10b5-1 plan must be adopted at a time when you are not in possession of Inside Information and must either specify (including by formula) the amount, pricing and timing of transactions in advance or delegate discretion on those matters to an independent third party. You may not adopt or amend a 10b5-1 plan at a time when you are subject to a black-out period, as discussed below. Once a 10b5-1 plan is adopted, you must not exercise any influence over the amount of securities to be traded, the price at which they are to be traded or the date of the trade. Centene requires that all 10b5-1 plans, and any amendment, suspension and termination of such plans, be approved in writing in advance by the General Counsel, and meet the requirements of Rule 10b5-1(c) under the Exchange Act, including:

- 10b5-1 plans may not provide for trades (i) if you are a “Section 16 Person” as defined below, until the later of (a) 90 days after the adoption or amendment of the 10b5-1 plan or (b) two business days following Centene’s filing of the Form 10-Q or 10-K for the quarter in which the 10b5-1 plan was adopted or amended, for a maximum of 120 days after the adoption or amendment of the 10b5-1 plan, or (ii) if you are not a Section 16 Person, until at least 30 days following the adoption or amendment of the 10b5-1 plan. The period of delayed effectiveness after adoption or amendment of a 10b5-1 plan is called a “cooling-off period.”
- You may not have more than one 10b5-1 plan in effect for open market purchases or sales of Centene securities, except in the following circumstances:
  - This prohibition does not apply to 10b5-1 plans authorizing a written, irrevocable election (an “election”) to sell a portion of shares as necessary to satisfy statutory tax withholding obligations arising solely from the vesting of compensatory awards (not including options) (“sales to cover”), provided that (i) the election is made outside a black-out period, (ii) at the time of the election, you are not in possession of any Inside Information, (iii) the sales to cover are made in good faith and not as part of a plan or scheme to evade the prohibitions of Exchange Act Rule 10b-5, (iv) you do not have, and will not attempt to exercise, authority, influence or control over any such sales to cover, and (v) the election contains appropriate representations as to clauses (ii)-(iv);<sup>1</sup>
  - You may maintain two separate 10b5-1 plans, provided that trading under the later-commencing 10b5-1 plan is not authorized to begin until after all trades under the earlier-commencing 10b5-1 plan are completed or have expired without execution (subject to any applicable cooling-off periods), and provided further that if you terminate an earlier-commencing 10b5-1 plan (i.e., the earlier-commencing plan does not end by its terms and without any action by you), the later-commencing 10b5-1 plan will be subject to a cooling-off period beginning on the termination date of the earlier-commencing plan; and
  - A series of separate contracts with different brokers to execute trades under a 10b5-1 plan may be treated as a single plan, provided that this arrangement and each contract have been pre-cleared in writing by the General Counsel and meet the conditions under Exchange Act Rule 10b5-1, and provided further that any amendment of one contract is treated as an amendment of all of the contracts under the plan.

In any 12-month period, you may not enter into more than one “single-trade” 10b5-1 plan (i.e., a 10b5-1 plan designed to effect the open market purchase or sale of the total amount of Centene securities subject to the plan as a single transaction). This prohibition does not apply to plans (i) authorizing sales to cover, provided that you do not control the timing of such sale or (ii) that give discretion to an agent over whether to execute the 10b5-1 plan as a single transaction or that provide the agent’s future acts depend on facts not known at the time of the 10b5-1 plan’s adoption and might reasonably result in multiple transactions.

- Any Section 16 Person adopting or modifying a 10b5-1 plan must include in the 10b5-1 plan a written representation certifying that he or she (i) is not aware of Inside Information and (ii) is adopting or modifying the 10b5-1 plan in good faith and not as part of a plan or scheme to evade the prohibitions of Exchange Act Rule 10b-5.
- You may make amendments to 10b5-1 plans without triggering a cooling-off period so long as the amendment does not change the pricing provisions of the 10b5-1 plan, the amount of securities covered under the 10b5-1 plan or the timing of trades under the 10b5-1 plan, or where a broker executing trades on your behalf is substituted by a different broker (so long as the purchase or sales instructions remain the same).

Purchases or sales of Centene securities executed pursuant to a valid 10b5-1 plan approved as provided herein are not subject to the trading restrictions covered by this Policy.

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<sup>1</sup> Note: The Company’s equity awards granted to employees generally provide for the forfeiture to Centene of equity to cover tax withholding obligations upon vesting as set forth under “*Equity Grants*”.

**Equity Grants.** Certain transactions between you and Centene with respect to grants to you under its equity incentive plans (or, to the extent applicable, granted outside such plans) are not subject to the trading restrictions covered by this Policy. Such transactions include, without limitation, the following:

- the exercise of stock options by paying Centene the exercise price, plus an amount equal to the related tax withholding obligations, in cash (generally referred to as an “exercise-and-hold” transaction);
- the exercise of stock options on a “net exercise” basis pursuant to which an optionee either (i) delivers to Centene outstanding shares of Centene stock or (ii) authorizes Centene to withhold from issuance shares of stock issuable upon exercise of the option, in either case, having a fair market value on the date of exercise equal to the aggregate exercise price;
- the forfeiture to Centene of restricted stock, restricted stock units, or performance stock units, to cover withholding tax obligations upon vesting of restricted stock, restricted stock units or performance stock units; or
- purchases of Centene stock pursuant to Centene’s employee stock purchase plan, deferred compensation plan and/or 401(k) plan resulting from your periodic contribution of money to the plan pursuant to an election you make at the time you enroll in the plan, provided that that the trading restrictions contained in this Policy would apply to your election to participate in an employee stock purchase plan for any enrollment period, and to your subsequent sales of Centene stock purchased pursuant to the plan.

Thus, restrictions contained in this Policy would apply to the sale of Centene stock in the open market to pay the exercise price of an option and to the “cashless exercise” affected through a broker or “same day sale” of an option. In addition, any sale of the underlying stock acquired upon the exercise of a stock option is subject to the Policy.

**Gifts.** Bona fide gifts of Centene securities (e.g., to charities, churches, non-profit organizations) should only be made (i) when you are not in possession of Inside Information and (ii) for Restricted Persons, outside a black-out period. Gifts of Centene securities are otherwise subject to the trading restrictions covered by this Policy. In addition, if you are a “Section 16 Person” as defined below, you will need to obtain pre-clearance for any gifts.

**Prohibitions.** In addition to the other restrictions set forth in this Policy, the following transactions are strictly prohibited at all times:

- trading in call or put options involving Centene securities and other derivative securities;
- engaging in short sales of Centene securities;
- holding Centene securities in a margin account;
- hedging (directly or indirectly) Centene securities, or otherwise engage in transactions that hedge or offset, or are designed to hedge or offset, any decrease in the market value of Centene securities, including (but not limited to) collars, equity swaps, exchange funds and prepaid variable forward sale contracts; and
- pledging Centene’s securities, including to secure margin or other loans or to purchase Centene securities on margin.

If you are unsure whether or not a particular transaction is prohibited under this Policy, you should consult with Centene’s General Counsel, prior to engaging in, or entering into an agreement, understanding or arrangement to engage in, such transaction.

### **C. Applicability of Policy to Material, Non-public Information Regarding Other Companies**

This Policy and the guidelines described herein also apply to material, non-public information relating to other companies, including Centene's customers, vendors, suppliers, competitors or possible acquisition targets, when that information is obtained in the course of employment with, or while performing other services on behalf of, Centene. All employees should treat material non-public information about other companies with the same care required with respect to information related directly to Centene.

### **D. Post-Termination Transactions**

This Policy continues to apply following termination of employment with, or cessation of service to, Centene as follows: if you are aware of Inside Information when your employment or service relationship terminates, you may not engage in transactions involving Centene securities until that information has become public or is no longer material. In all other respects, the procedures set forth in this Policy will cease to apply to your transactions in Centene securities at the time of your termination of employment or service.

### **E. Applicability of U.S. Securities Laws to International Transactions**

The U.S. securities laws may be applicable to trades in Centene's securities executed outside the United States, as well as to the securities of Centene's subsidiaries or affiliates, even if they are located outside the United States or if you are located outside the United States. Transactions involving securities of subsidiaries or affiliates should be carefully reviewed by counsel for compliance not only with local law but also for possible application of U.S. securities laws.

## **III. GENERAL POLICY**

### **A. Possession of Information**

No director, employee, consultant or contractor of Centene or its subsidiaries who is in possession of Inside Information may, either directly or indirectly (including, without limitation, through a Family Member (as defined below), friend, anyone to whom you provide significant financial support or entity in which you or any of your Family Members is a director, officer or controlling equity holder or beneficiary), (a) purchase or sell Centene's securities, (b) engage in any other action to take advantage of Inside Information or (c) provide Inside Information to any other person outside of Centene, including Family Members and friends. These restrictions do not apply to transactions specifically exempt from this Policy, including transactions made under an approved 10b5-1 plan and transactions between you and Centene with respect to grants under its equity incentive plans (or, to the extent applicable, granted outside such plans). For purposes of this Policy, "Family Members" refers to spouses, domestic partners, and minor children (even if financially independent).

In addition, Centene itself must comply with U.S. securities laws applicable to its own securities trading activities, and will not effect transactions in respect of its securities, or adopt any securities repurchase plans, when it is in possession of Inside Information, other than in compliance with applicable law, subject to the policies and procedures adopted by Centene, if applicable, and the prior approval of the General Counsel.

### **B. "Tipping" of Information**

Persons subject to this Policy may not disclose, convey or "tip" Inside Information to any person by providing him or her with Inside Information other than to disclose on a "need to know" basis to Centene employees or representatives in the course of performing their duties for Centene. When sharing Inside Information with other Centene employees or representatives, such information should be confined to as small a group as possible and the importance of the limited use of such information should be conveyed to the recipient. Unlawful tipping includes passing on Inside Information to friends, family members or acquaintances under circumstances that suggest that persons subject to this Policy were trying to help the recipients of such information make a profit or avoid a loss by trading in Centene securities based on such information.

## IV. SPECIFIC POLICIES

### A. Black-out Periods

All those listed on Schedule A hereto (as may be amended from time to time by the General Counsel), as well as any other persons (whether Family Members or not) that reside in the same household as those persons (all of the foregoing being “Restricted Persons”) are subject to additional restrictions on their ability to engage in purchase or sale transactions involving Centene securities. Centene believes Restricted Persons are more likely to have access to Inside Information regarding Centene because of their positions with Centene and, as a result, their trades in Centene securities are more likely to be subject to greater scrutiny. Accordingly, except as otherwise provided in this Policy with regard to purchases and/or sales of Centene stock pursuant to an approved 10b5-1 plan, Restricted Persons are prohibited from trading in Centene securities, and from entering into or amending a 10b5-1 plan, during the period beginning on the 7<sup>th</sup> calendar day prior to the end of each fiscal quarter and ending immediately prior to the opening of the market on the 2nd full trading day following public disclosure of the financial results for that quarter or the full year. For example, if Centene were to publicly disclose its financial results for a quarter on a Tuesday before the market opened, Wednesday would be the first eligible trading day for Restricted Persons.

In addition, from time to time, Centene will impose special black-out periods on Restricted Persons and other employees if, in the judgment of the General Counsel, it is likely that such person or persons have become aware of significant corporate developments that may be material and have not yet been disclosed to the public, even when trading otherwise may be permitted. In the event that certain Restricted Persons or other employees become subject to a special black-out period, such persons are prohibited from (a) trading in Centene securities and (b) disclosing to others the fact they are subject to such special black-out period. These special black-out periods may vary in length and may or may not be broadly communicated to Centene employees. Centene would re-open trading at the beginning of the 2nd day following the date of public disclosure of such significant corporate developments, or when Centene no longer has Inside Information.

### B. Pre-clearance

Except as otherwise provided in the following paragraph, members of the Board of Directors of Centene and “officers” (as such term is defined in Rule 16a-1(f) under the Exchange Act) of Centene (each, a “Section 16 Person”) must obtain written pre-clearance from the General Counsel before such Section 16 Person makes any purchases, sales or gifts of Centene’s securities, regardless of whether or not a black-out period is then in effect. The request for pre-clearance must be sent to the General Counsel at least two business days prior to commencing the trade. In evaluating each proposed transaction, the General Counsel will consult as necessary with senior management and/or outside counsel before clearing any proposed trade. Pre-clearance of a proposed transaction is valid for no more than five trading days immediately following receipt by the Section 16 Person of such clearance. If the transaction does not take place during that time, the Section 16 Person must re-request pre-clearance through the same process. The General Counsel is under no obligation to approve a transaction submitted for pre-clearance. If pre-clearance is denied, the fact of such denial must be kept confidential by the Section 16 Person requesting such pre-clearance. The approval of pre-clearance of a transaction is subject to revocation at any time prior to the sale or purchase in the sole discretion of the General Counsel.

Pre-clearance does not constitute legal advice, does not constitute confirmation that you do not possess Inside Information, does not insulate you from liability for insider trading and does not relieve you of your obligations under federal and state securities laws; it is a safeguard that Centene has put in place to help protect you and Centene.

A person subject to this Policy does not need to receive pre-clearance for trades pursuant to an approved 10b5-1 plan, but must receive prior approval from the General Counsel before adopting, amending, suspending or terminating such a plan. In evaluating the proposed 10b5-1 plan, or the amendment, suspension or termination of an existing 10b5-1 plan, the General Counsel will consult as necessary with senior management and/or outside counsel before approving a proposed 10b5-1 plan (or any amendment, suspension or termination of an existing plan). Approval to adopt, amend, suspend or terminate a 10b5-1 plan is valid for no more than the five trading days immediately following receipt by the person requesting such approval. If approval is denied, the fact of such denial must be kept confidential by the person requesting such approval. The prior approval of a 10b5-1 plan is subject to revocation at any time prior to the implementation of the plan in the sole discretion of the General Counsel. The General Counsel is under no obligation to approve a 10b5-1 plan submitted for approval.

Prior approval of a 10b5-1 plan does not constitute legal advice, does not constitute confirmation that you do not possess Inside Information at the time you enter into a 10b5-1 plan, does not insulate you from liability for insider trading and does not relieve you of your obligations under federal and state securities laws.

### **C. Notification**

Section 16 Persons must report, or cause such person's broker to report, within 24 hours following a transaction involving Centene's securities, including purchases, sales, gifts, transfers, pledges and 10b5-1 plan transactions, to Centene's Corporate Controller or Assistant Controller the details of such transaction in writing.

### **V. COMPLIANCE**

All persons subject to this Policy must promptly report to Centene's Compliance Department, pursuant to the procedures set forth in Centene's Business Ethics and Code of Conduct, including through the use of Centene's Ethics & Compliance Helpline at 1-800-345-1642, any trading in Centene's securities by Centene personnel, or any disclosure of Inside Information or material, non-public information concerning other companies by Centene personnel, that such person has reason to believe may violate this Policy or federal or state securities laws.

### **VI. ADDITIONAL INFORMATION**

#### ***What is Inside Information?***

"Inside information" is material, non-public information related to, affecting or regarding Centene or its subsidiaries. Information generally becomes available to the public when it is made available on a broad-based non-exclusionary basis (e.g., when it has been disclosed by Centene or third parties in a press release or other authorized public statement, including any filing with the SEC). In general, information is considered to have been made available to the public on the second trading day after the formal release of the information. In other words, there is a presumption that the public needs approximately one complete trading day to receive and absorb such information.

#### ***What is Material Information?***

As a general rule, information about Centene (or another company) is "material" if it could reasonably be expected to affect someone's decision to buy, hold or sell Centene's securities (or the securities of another company), and if it could be viewed by a reasonable investor as having significantly altered the "total mix" of information made available. In particular, information is considered to be material if its disclosure to the public would be reasonably likely to affect an investor's decision to buy, hold or sell the securities of the company to which the information relates, or the market price of that company's securities. Material information can be favorable or unfavorable. While it is not possible to identify in advance all information that will likely be deemed to be material, some examples of information that may be material would include the following:

- significant changes in financial results and/or financial condition and financial projections;
- news of major new contracts or possible loss of business;
- dividends or stock splits;
- changes in the board, management or control;
- significant mergers, acquisitions, reorganizations, tender offers, dispositions of assets or joint ventures;
- significant litigation or regulatory developments;
- significant data breaches or similar cybersecurity events;
- significant increases or decreases in the amount of outstanding securities or indebtedness;
- changes in debt ratings, or analyst upgrades or downgrades of the issuer or one of its securities;
- significant changes in accounting treatment, write-offs or effective tax rate;
- liquidity problems or impending bankruptcy;
- changes in auditors or auditor notification that the company may no longer rely on an audit report; and
- transactions with directors, officers or principal security holders.

It can sometimes be difficult to know whether information would be considered “material.” The determination whether information is material is almost always clearer after the fact, when the effect of that information on the market may be more susceptible to quantification. Although you may have information about Centene that you do not consider to be material, federal regulators and others may conclude (with the benefit of hindsight) that such information was material. Therefore, trading in Centene securities when you possess non-public information about Centene can be risky. When doubt exists, the information should be presumed to be material. If you are unsure whether you are in possession of material, non-public information, you should consult with Centene’s General Counsel, prior to engaging in, or entering into an agreement, understanding or arrangement to engage in, a purchase or sale transaction involving Centene securities.

### ***Twenty-Twenty Hindsight***

If securities transactions ever become the subject of scrutiny, they are likely to be viewed after-the-fact with the benefit of hindsight. As a result, before engaging in any transaction you should carefully consider how your transaction may be construed in the bright light of hindsight. Again, in the event of any questions or uncertainties about the Policy, please consult with Centene’s General Counsel.

### ***What is the Penalty for Insider Trading?***

Trading on Inside Information is a crime. The consequences of insider trading and tipping are severe and may, in some cases, be applied to a Centene company or manager as well as to the individual who illegally trades or tips. Possible consequences include criminal prosecution with the potential for prison terms and additional fines up to three times of the profits earned if convicted, in addition to civil penalties (up to three times of the profits earned), termination of employment and personal embarrassment resulting from adverse publicity.

## **VII. REVIEW**

This Policy is subject to the periodic review of the Audit and Compliance Committee (the “Audit and Compliance Committee”) of the Board. Any proposed changes will be reviewed by the Audit and Compliance Committee and recommended to the Board for its approval.

## **VIII. CERTIFICATION**

The Company shall take reasonable steps designed to ensure that all employees and directors of the Company and are educated about, and periodically reminded of, the federal securities law restrictions and Company policies regarding insider trading. Employees and directors shall be required to certify their understanding of, and intent to comply with, the Company’s insider trading policy.

If you have any questions with regard to this Policy, you should consult with Centene’s General Counsel.

## List of Subsidiaries as of December 31, 2024

Absolute Total Care, Inc, a South Carolina corporation  
 AcariaHealth Pharmacy #11, Inc, a Texas corporation  
 AcariaHealth Pharmacy #12, Inc, a New York corporation  
 AcariaHealth Pharmacy #13, Inc, a California corporation  
 AcariaHealth Pharmacy #14, Inc, a California corporation  
 AcariaHealth Pharmacy #26, Inc, a Delaware corporation  
 AcariaHealth Pharmacy, Inc, a California corporation  
 AcariaHealth, Inc., a Delaware corporation  
 Access Medical Acquisition, LLC, a Delaware LLC  
 Access Medical Group of Florida City, LLC, a Florida LLC  
 Access Medical Group of Hialeah, LLC, a Florida LLC  
 Access Medical Group of Kendall, LLC, a Florida LLC  
 Access Medical Group of Lakeland, LLC, a Florida LLC  
 Access Medical Group of Lauderdale Lakes, LLC, a Florida LLC  
 Access Medical Group of Margate, LLC, a Florida LLC  
 Access Medical Group of Miami, LLC, a Florida LLC  
 Access Medical Group of North Miami Beach, LLC, a Florida LLC  
 Access Medical Group of Opa-Locka, LLC, a Florida LLC  
 Access Medical Group of Pembroke Pines, LLC, a Florida LLC  
 Access Medical Group of Perrine, LLC, a Florida LLC  
 Access Medical Group of Riverview, LLC, a Florida LLC  
 Access Medical Group of Tampa II, LLC, a Florida LLC  
 Access Medical Group of Tampa III, LLC, a Florida LLC  
 Access Medical Group of Tampa, LLC, a Florida LLC  
 Access Medical Group of Westchester, LLC, a Florida LLC  
 Agate Resources, Inc., an Oregon corporation  
 Ambetter Health of Florida, Inc., a Florida corporation  
 Ambetter Health of Louisiana, Inc., a Louisiana corporation  
 Ambetter Health of Texas, Inc., a Texas corporation  
 Ambetter of Magnolia, Inc, a Mississippi corporation  
 Ambetter of North Carolina, Inc., a North Carolina corporation  
 Ambetter of Peach State Inc., a Georgia corporation  
 American Progressive Life and Health Insurance Company of New York, a New York corporation  
 America's 1st Choice California Holdings, LLC, a Florida corporation  
 Ardan TacOpps I, LLC, a Delaware LLC  
 Arizona Biodyne, Inc., an Arizona corporation  
 Arkansas Health & Wellness Health Plan, Inc., an Arkansas corporation  
 Arkansas Total Care, Inc., an Arkansas corporation  
 Aurelia Health, LLC, an Arizona corporation  
 Bankers Reserve Life Insurance Company of Wisconsin, a Wisconsin corporation  
 Bridgeway Health Solutions of Arizona, Inc., an Arizona corporation  
 Bridgeway Health Solutions, LLC, a Delaware LLC  
 Buckeye Community Health Plan, Inc, an Ohio corporation  
 Buckeye Health Plan Community Solutions, Inc., an Ohio corporation  
 California Health and Wellness Plan, a California corporation  
 Carolina Complete Health Holding Company Partnership, a Delaware partnership

Carolina Complete Health, Inc., a North Carolina corporation  
Celtic Group, Inc, a Delaware corporation  
Celtic Insurance Company, an Illinois corporation  
Cenpatco Behavioral Health, LLC, a California LLC  
Centene Center I, LLC, a Delaware LLC  
Centene Center II, LLC, a Delaware LLC  
Centene Center LLC, a Delaware LLC  
Centene Health Plan Holdings, Inc., a Delaware corporation  
Centene Institute for Advanced Health Education, LLC, a Delaware LLC  
Centene Management Company LLC, a Wisconsin LLC  
Centene Pharmacy Services, Inc., a Delaware corporation  
Centene Venture Company Alabama Health Plan, Inc., an Alabama corporation  
Centene Venture Company Florida, Inc., a Florida corporation  
Centene Venture Company Illinois, Inc., an Illinois corporation  
Centene Venture Company Indiana, Inc., an Indiana corporation  
Centene Venture Company Kansas, Inc., a Kansas corporation  
Centene Venture Company Michigan, Inc., a Michigan corporation  
Centene Venture Company Tennessee, Inc., a Tennessee corporation  
Centene Venture Insurance Company Texas, Inc., a Texas corporation  
CMC Real Estate Company, LLC, a Delaware LLC  
Cobalt Therapeutics, LLC, a Delaware LLC  
Community Medical Holdings Corp, a Delaware corporation  
Comprehensive Health Management, LLC, a Florida LLC  
Coordinated Care Corporation, an Indiana corporation  
Coordinated Care of Washington, Inc, a Washington corporation  
Delaware First Health Complete, Inc., a Delaware corporation  
Delaware First Health, Inc., a Delaware corporation  
DeNova Collaborative Health, LLC, an Arizona LLC  
District Community Care Inc., a Washington D.C. corporation  
Involve Benefits Options, Inc., a Delaware corporation  
Involve Dental IPA of New York, Inc., a New York corporation  
Involve Dental of Florida, Inc., a Florida corporation  
Involve Dental of Texas, Inc., a Texas corporation  
Involve Dental, Inc., a Delaware corporation  
Involve Holdings, LLC, a Delaware LLC  
Involve Pharmacy IPA, LLC, a New York LLC  
Involve Total Vision, Inc., a Delaware corporation  
Involve Vision Benefits, Inc., a Delaware corporation  
Involve Vision IPA of New York, Inc., a New York corporation  
Involve Vision of Florida, Inc., a Florida corporation  
Involve Vision of Texas, Inc., a Texas corporation  
Involve Vision, Inc., a Delaware corporation  
Involve, Inc., a Delaware corporation  
Foundation Care, LLC, a Missouri LLC  
Granite State Health Plan, Inc, a New Hampshire corporation  
Harmony Health Plan, Inc., an Illinois corporation  
Harmony Health Systems Inc., a New Jersey corporation  
Health Care Enterprises, LLC, a Delaware LLC  
Health Net Community Solutions of Arizona, Inc., an Arizona corporation

Health Net Community Solutions, Inc., a California corporation  
Health Net Federal Services, LLC, a Delaware LLC  
Health Net Health Plan of Oregon, Inc., an Oregon corporation  
Health Net Life Insurance Company, a California corporation  
Health Net Life Reinsurance Company, a Cayman Islands corporation  
Health Net of Arizona, Inc., an Arizona corporation  
Health Net of California, Inc., a California corporation  
Health Net, LLC, a Delaware LLC  
Health Plan Real Estate Holdings, Inc., a Missouri corporation  
Healthy Louisiana Holdings LLC, a Delaware LLC  
Healthy Missouri Holdings, Inc, a Missouri corporation  
Healthy Washington Holdings, Inc, a Delaware corporation  
Heritage Health Systems of Texas, Inc., a Texas corporation  
Heritage Health Systems, Inc., a Texas corporation  
HHS Texas Management, Inc., a Texas corporation  
HHS Texas Management, LP, a Texas limited partnership  
HLM Strategic Investment Fund, L.P., a Delaware limited partnership  
Home State Health Plan, Inc, a Missouri corporation  
HomeScripts.com, LLC, a Michigan LLC  
Human Affairs International of California, a California corporation  
Illinois Health Practice Alliance, LLC, a Delaware corporation  
Integrated Mental Health Services, a Texas corporation  
Interpreta Holdings, Inc., a Delaware corporation  
Interpreta, Inc., a Delaware corporation  
Iowa Total Care, Inc, an Iowa corporation  
LifeShare Management Group, LLC, a New Hampshire LLC  
Louisiana Healthcare Connections, Inc, a Louisiana corporation  
Magellan Behavioral Health of Florida, Inc., a Florida corporation  
Magellan Behavioral Health of New Jersey, LLC, a New Jersey LLC  
Magellan Behavioral Health of Pennsylvania, Inc., a Pennsylvania corporation  
Magellan Behavioral Health Systems, LLC, a Utah LLC  
Magellan Behavioral of Michigan, Inc., a Michigan corporation  
Magellan Capital, LLC, a Nevada LLC  
Magellan Cares Foundation, Inc., a Delaware corporation  
Magellan Complete Care of Louisiana, Inc., a Louisiana corporation  
Magellan Complete Care of Pennsylvania, Inc., a Pennsylvania corporation  
Magellan Financial, Inc., a Virginia corporation  
Magellan Financial Capital, LLC, a Delaware LLC  
Magellan Health Q10, LLC, a Nebraska LLC  
Magellan Health Services of Arizona, Inc., an Arizona corporation  
Magellan Health Services of California, Inc. - Employer Services, a California corporation  
Magellan Health Services of New Mexico, Inc., a New Mexico corporation  
Magellan Health, Inc, a Delaware corporation  
Magellan Healthcare Provider Group, Inc., a Maryland corporation  
Magellan Healthcare, Inc., a Delaware corporation  
Magellan HRSC, Inc., an Ohio corporation  
Magellan Life Insurance Company, a Delaware corporation  
Magellan of Georgia, Inc., a Georgia corporation  
Magellan of Idaho, LLC, an Idaho LLC

Magellan of Maryland, LLC, a Maryland LLC  
Magellan of Nevada, LLC, a Nevada LLC  
Magellan Pharmacy Services, Inc., a Delaware corporation  
Magellan Providers of Texas, Inc., a Texas corporation  
Magnolia Health Plan, Inc, a Mississippi corporation  
Magnolia Joint Venture Holding Company, Inc., a Delaware corporation  
Managed Health Network, a California corporation  
Managed Health Network, LLC, a Delaware LLC  
Managed Health Services Insurance Corporation, a Wisconsin corporation  
Meridian Health Plan of Illinois, Inc., an Illinois corporation  
Meridian Health Plan of Michigan, Inc., a Michigan corporation  
Meridian Management Company, LLC, a Michigan LLC  
Meridian Network Services, LLC, a Michigan LLC  
MeridianRx IPA, LLC, a New York LLC  
MeridianRx of Indiana, LLC, a Michigan LLC  
MeridianRx, LLC, a Michigan LLC  
Merit Behavioral Care Corporation, a Delaware corporation  
MHN Services, LLC, a California LLC  
Nebraska Total Care, Inc., a Nebraska corporation  
Network Providers, LLC, a Delaware LLC  
New York Quality Healthcare Corporation, a New York corporation  
Next Door Neighbors, Inc., a Delaware corporation  
Next Door Neighbors, LLC., a Delaware LLC  
Novasys Health, Inc, a Delaware corporation  
Ohana Health Plan, Inc., a Hawaii corporation  
Oklahoma Complete Health Holding Company, LLC, a Delaware LLC  
Oklahoma Complete Health Inc., an Oklahoma corporation  
One Care by Care 1st Health Plan of Arizona, Inc., an Arizona corporation  
P.P.C., Inc., a Missouri corporation  
Peach State Health Plan, Inc, a Georgia corporation  
Penn Marketing America, LLC, a Delaware LLC  
Pennsylvania Health and Wellness, Inc., a Pennsylvania corporation  
PPC Group, Inc., a Delaware corporation  
Premier Marketing Group, LLC, a Delaware LLC  
Presonyx, Inc., a Delaware corporation  
QCA Health Plan, Inc., an Arkansas corporation  
Qualchoice Life and Health Insurance Company, Inc., an Arkansas corporation  
Rhythm Health Tennessee, Inc., a Tennessee corporation  
RI Health & Wellness, Inc., a Rhode Island corporation  
SelectCare of Texas, Inc., a Texas corporation  
SilverSummit Healthplan, Inc., a Nevada corporation  
Social Health Bridge Trust, a Delaware trust  
Social Health Bridge, LLC, a Delaware LLC  
Specialty Therapeutic Care Holdings, LLC, a Delaware LLC  
Sunflower State Health Plan, Inc, a Kansas corporation  
Sunshine Health Community Solutions, Inc., a Florida corporation  
Sunshine Health Holding LLC, a Florida LLC  
Sunshine State Health Plan, Inc, a Florida corporation  
Superior Health Management Advisors, LLC

Superior HealthPlan, Inc, a Texas corporation  
The WellCare Management Group, Inc., a New York corporation  
Transplant Health Solutions IPA, Inc., a New York corporation  
Trillium Community Health Plan, Inc., an Oregon corporation  
U.S. IPA Providers, Inc., a New York corporation  
UAM Agent Services Corp., an Iowa corporation  
Universal American Corp., a Delaware corporation  
Universal American Financial Services, Inc., a Delaware corporation  
Universal American Holdings, LLC, a Delaware LLC  
WCG Health Management, Inc., a Delaware corporation  
WellCare Health Insurance Company of America, an Arkansas corporation  
WellCare Health Insurance Company of Kentucky, Inc., a Kentucky corporation  
WellCare Health Insurance Company of Louisiana, Inc., a Louisiana corporation  
WellCare Health Insurance Company of Nevada, Inc., a Nevada corporation  
WellCare Health Insurance Company of New Hampshire, Inc., a New Hampshire corporation  
WellCare Health Insurance Company of New Jersey, Inc., a New Jersey corporation  
WellCare Health Insurance Company of Oklahoma, Inc., an Oklahoma corporation  
WellCare Health Insurance Company of Washington, Inc., a Washington corporation  
WellCare Health Insurance of Arizona, Inc., an Arizona corporation  
WellCare Health Insurance of Connecticut, Inc., a Connecticut corporation  
WellCare Health Insurance of Hawaii, Inc., a Hawaii corporation  
WellCare Health Insurance of New York, Inc., a New York corporation  
WellCare Health Insurance of North Carolina, Inc., a North Carolina corporation  
WellCare Health Insurance of Tennessee, Inc., a Tennessee corporation  
WellCare Health Insurance of the Southwest, Inc., an Arizona corporation  
WellCare Health Plans of Kentucky, Inc., a Kentucky corporation  
WellCare Health Plans of Massachusetts, Inc, a Massachusetts corporation  
WellCare Health Plans of Missouri, Inc., a Missouri corporation  
WellCare Health Plans of New Jersey, Inc., a New Jersey corporation  
WellCare Health Plans of Rhode Island, Inc., a Rhode Island corporation  
WellCare Health Plans of Vermont, Inc., a Vermont corporation  
WellCare Health Plans, Inc., a Delaware corporation  
WellCare National Health Insurance Company, a Texas corporation  
WellCare of Alabama, Inc., an Alabama corporation  
WellCare of California, Inc., a California corporation  
WellCare of Connecticut, Inc., a Connecticut corporation  
WellCare of Georgia, Inc., a Georgia corporation  
WellCare of Illinois, Inc., an Illinois corporation  
WellCare of Indiana, Inc., an Indiana corporation  
WellCare of Maine, Inc., a Maine corporation  
WellCare of Michigan Holding Company, a Michigan corporation  
WellCare of Mississippi, Inc., a Mississippi corporation  
WellCare of Missouri Health Insurance Company, Inc., a Missouri corporation  
WellCare of New Hampshire, Inc., a New Hampshire corporation  
WellCare of North Carolina, Inc., a North Carolina corporation  
WellCare of Oklahoma, Inc., an Oklahoma corporation  
WellCare of Pennsylvania, Inc., a Pennsylvania corporation  
WellCare of South Carolina, Inc., a South Carolina corporation  
WellCare of Texas, Inc., a Texas corporation

WellCare of Virginia, Inc., a Virginia corporation

WellCare of Washington, Inc., a Washington corporation

WellCare Prescription Insurance, Inc., an Arizona corporation

Western Sky Community Care, Inc., a New Mexico corporation

Worlco Management Services, Inc., a New York corporation

**Consent of Independent Registered Public Accounting Firm**

We consent to the incorporation by reference in the registration statements Nos. 333-261993, 333-255735, 333-238597, 333-236036, 333-217634, 333-210376, 333-197737, 333-180976, and 333-90976 on Form S-8 and in the registration statement No. 333-277218 on Form S-3 of our reports dated February 18, 2025, with respect to the consolidated financial statements of Centene Corporation and the effectiveness of internal control over financial reporting.

/s/ KPMG LLP

St. Louis, Missouri  
February 18, 2025

## CERTIFICATION

I, Sarah M. London, certify that:

1. I have reviewed this Annual Report on Form 10-K of Centene Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
  - a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
  - b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
  - c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
  - d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
  - a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
  - b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 18, 2025

/s/ SARAH M. LONDON  
Chief Executive Officer  
(principal executive officer)

## CERTIFICATION

I, Andrew L. Asher, certify that:

1. I have reviewed this Annual Report on Form 10-K of Centene Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
  - a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
  - b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
  - c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
  - d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
  - a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
  - b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 18, 2025

/s/ ANDREW L. ASHER

Executive Vice President, Chief Financial Officer  
(principal financial officer)

**CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,  
AS ADOPTED PURSUANT TO  
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Annual Report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2024, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Sarah M. London, Chief Executive Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

- (1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
- (2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 18, 2025

/s/ SARAH M. LONDON  
Chief Executive Officer  
(principal executive officer)

**CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,  
AS ADOPTED PURSUANT TO  
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Annual Report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2024, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Andrew L. Asher, Executive Vice President and Chief Financial Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

- (1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
- (2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 18, 2025

/s/ ANDREW L. ASHER

Executive Vice President, Chief Financial Officer  
(principal financial officer)