MAGELLAN HEALTH INC
Form 10-K
February 28, 2019
Table of Contents

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10 K

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

Commission File No. 1 6639

MAGELLAN HEALTH, INC.

(Exact name of registrant as specified in its charter)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DOCUMENTS INCORPORATED BY REFERENCE

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

Table of Contents

MAGELLAN HEALTH, INC.

REPORT ON FORM 10 K

For the Fiscal Year Ended December 31, 2018

Table of Contents

		Page
	PART I	
Item 1.	Business	1
Item 1A.	Risk Factors	15
Item 1B.	Unresolved Staff Comments	29
Item 2.	Properties	29
Item 3.	Legal Proceedings	29
Item 4.	Mine Safety Disclosures	30
	PART II	
Item 5.	Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities	31
Item 6.	Selected Financial Data	32
Item 7.	Management's Discussion and Analysis of Financial Condition and Results of Operations	33
Item 7A.	Quantitative and Qualitative Disclosures about Market Risk	52
Item 8.	Financial Statements and Supplementary Data	52
Item 9.	Changes in and Disagreements with Accountants on Accounting and Financial Disclosure	52
Item 9A.	Controls and Procedures	53
Item 9B.	Other Information	55
	PART III	
Item 10.	Directors and Executive Officers of the Registrant	56
Item 11.	Executive Compensation	56
Item 12.	Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters	56
Item 13.	Certain Relationships and Related Transactions and Director Independence	56
Item 14.	Principal Accounting Fees and Services	56
	PART IV	
Item 15.	Exhibits, Financial Statement Schedule and Additional Information	57
Item 16.	Form 10-K Summary	61

Table of Contents

PART I

Cautionary Statement Concerning Forward Looking Statements

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

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

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

Item 1. Business

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

Healthcare

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

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

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

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

Table of Contents

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

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

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

Pharmacy Management

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

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

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

Corporate

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

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

Recent Acquisitions

Healthcare Acquisitions

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

Table of Contents

Pharmacy Management Acquisitions

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

Industry

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

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

Business Strategy

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

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

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

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

Maximize and expand Magellan's key value drivers:

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

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

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

Table of Contents

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

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

Customer Contracts

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

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

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

Provider Network

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

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

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

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

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

Competition

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

Insurance

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

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

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

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

Regulation

General

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

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Table of Contents

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

State Licensure and Regulation

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

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

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

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

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

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

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

6

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

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

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

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

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

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

Table of Contents

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

Employee Retirement Income Security Act (“ERISA”)

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

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

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

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

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

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

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

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

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

Table of Contents

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

Fraud, Waste and Abuse Laws

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

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

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

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

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

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

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

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

Table of Contents

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

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

Mental Health Parity

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

Health Care Reform

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

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

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

Table of Contents

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

Federal and State Medicaid Laws and Regulations

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

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

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

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

Medicare Laws and Regulations

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

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

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

Table of Contents

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

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

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

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

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

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

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

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

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

Other Federal and State Laws and Regulations

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

Table of Contents

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

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

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

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

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

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

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

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

Table of Contents

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

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

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

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

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

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

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

Employees of the Registrant

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

Table of Contents

Available Information

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

Item 1A. Risk Factors

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

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

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

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

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

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

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

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

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

Table of Contents

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

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

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

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

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

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

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

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

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

Table of Contents

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18

Table of Contents

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

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

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

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

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

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

Table of Contents

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

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

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

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

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

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

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

Table of Contents

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

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

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

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

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

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

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

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

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

Table of Contents

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

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

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

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

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

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

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

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

Table of Contents

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

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

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

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

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

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

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

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

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

Table of Contents

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

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

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

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

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

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

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

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

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

Table of Contents

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

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

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

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

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

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

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

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

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

Table of Contents

Pharmacy Management segment in the future.

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

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

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

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

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

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

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

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

Table of Contents

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

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

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

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

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

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

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

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

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

Table of Contents

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

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

Item 3. Legal Proceedings

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

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

Table of Contents

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

Item 4. Mine Safety Disclosures

Not applicable.

Table of Contents

PART II

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

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

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

Comparison of Cumulative Total Return

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

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

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

Table of Contents

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

Stock Repurchases

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

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

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

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

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

Dividends

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

Recent Sales of Unregistered Securities

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

Item 6. Selected Financial Data

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

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

Table of Contents

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

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

(In thousands, except per share amounts)

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

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

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

(2) Includes changes in fair value of contingent consideration of $6,172, $44,257, $(104), $696 and $1,307 for the years ended December 31, 2014, 2015, 2016, 2017 and 2018, respectively.
(3) Includes impairment of intangible assets of $4,800 for the year ended December 31, 2016.

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

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

Table of Contents

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

Business Overview

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

Summarized Results

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

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

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

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

Key Developments and Accomplishments

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

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

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

Results of Operations

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

Table of Contents

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

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

2018 compared to 2017

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

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

Depreciation and amortization

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

Interest Expense

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

Interest and other income

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

Income taxes

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

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

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

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

2017 compared to 2016

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

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

Depreciation and amortization

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

Interest expense

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

Interest and other income

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

Income taxes

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

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

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

Table of Contents

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

Segment Results

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

Healthcare

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

Table of Contents

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

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

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

2018 compared to 2017

Managed Care and Other Revenue

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

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

Table of Contents

Cost of Care

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

Direct Service Costs

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

2017 compared to 2016

Managed Care and Other Revenue

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

Cost of Care

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

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

Direct Service Costs

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

Table of Contents

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

Pharmacy Management

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

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

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

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

2018 compared to 2017

Managed Care and Other Revenue

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

Table of Contents

PBM and Dispensing Revenue

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

Cost of Goods Sold

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

Direct Service Costs

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

2017 compared to 2016

Managed Care and Other Revenue

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

PBM and Dispensing Revenue

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

Cost of Goods Sold

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

Direct Service Costs

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

Table of Contents

Corporate Segment

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

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

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

2018 compared to 2017

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

2017 compared to 2016

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

Inter segment revenues and expenses

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

Non GAAP Measures

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

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

Table of Contents

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

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

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

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

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

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

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

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

Outlook—Results of Operations

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

Table of Contents

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

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

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

Historical—Liquidity and Capital Resources

2018 compared to 2017

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

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

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

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

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

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

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

2017 compared to 2016

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

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

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

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

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

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

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

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

Outlook—Liquidity and Capital Resources

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

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

Table of Contents

Contractual Obligations and Commitments

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

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

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

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

Stock Repurchases

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

Off Balance Sheet Arrangements

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

Senior Notes

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

Table of Contents

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

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

Credit Agreements

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

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

Restrictive Covenants in Debt Agreements

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

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

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

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

Table of Contents

Critical Accounting Policies and Estimates

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

Cost of Care, Medical Claims Payable and Other Medical Liabilities

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

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

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

Table of Contents

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

	2016	2017	2018
Claims payable and IBNR, beginning of period	$ 253,299	$ 188,618	$ 326,642
Cost of care:			
Current year	1,892,914	2,421,270	3,772,112
Prior years(3)	(10,300)	(7,500)	(9,700)
Total cost of care	1,882,614	2,413,770	3,762,412
Claim payments and transfers to other medical liabilities(1):			
Current year	1,733,310	2,210,346	3,402,010
Prior years	213,985	161,798	292,904
Total claim payments and transfers to other medical liabilities	1,947,295	2,372,144	3,694,914
Acquisition of SWH	—	96,398	—
Claims payable and IBNR, end of period	188,618	326,642	394,140
Withhold (receivables) payable, end of period(2)	(4,482)	983	(593)
Medical claims payable, end of period	$ 184,136	$ 327,625	$ 393,547

(1) For any given period, a portion of unpaid medical claims payable could be covered by reinvestment liability (discussed below) and may not impact the Company's results of operations for such periods.
(2) Medical claims payable is offset by customer withholds from capitation payments in situations in which the customer has the contractual requirement to pay providers for care incurred.
(3) Favorable development in 2016, 2017 and 2018 was $10.3 million, $7.5 million and $9.7 million, respectively, and was mainly related to lower medical trends and faster claims completion than originally assumed.

Actuarial standards of practice require that the claim liabilities be adequate under moderately adverse circumstances. Adverse circumstances are situations in which the actual claims experience could be higher than the otherwise estimated value of such claims. In many situations, the claims paid amount experienced will be less than the estimate that satisfies the actuarial standards of practice. Any prior period favorable cost of care development related to a lack of moderately adverse conditions is excluded from "Cost of Care—Prior Years" adjustments, as a similar provision for moderately adverse conditions is established for current year cost of care liabilities and therefore does not generally impact net income.

Care trend factors and completion factors can have a significant impact on the medical claims payable liability. The following example provides the estimated impact to the Company's December 31, 2018 unpaid medical claims payable liability assuming hypothetical changes in care trend factors and completion factors:

Care Trend Factor(1)			Completion Factor(2)		
(Decrease) Increase			(Decrease) Increase		
Trend Factor		Medical Claims Payable (in thousands)	Completion Factor		Medical Claims Payable (in thousands)
−4	%	$ (22,500)	−2	%	$ (56,500)
−3	%	(16,500)	−1.5	%	(42,500)
−2	%	(11,000)	−1	%	(28,500)
−1	%	(5,500)	−0.5	%	(14,500)
1	%	5,500	0.5	%	14,500
2	%	11,000	1	%	29,000
3	%	16,500	1.5	%	44,000

4	%	22,500	2	%	59,000

Approximately 70 percent of IBNR dollars is based on care trend factors.

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(1) Assumes a change in the care trend factor for any month that a completion factor is not used to estimate incurred claims (which is generally any month that is less than 70 percent complete).

49

Table of Contents

(2) Assumes a change in the completion factor for any month for which completion factors are used to estimate IBNR (which is generally any month that is 70 percent or more complete).

Due to the existence of risk sharing and reinvestment provisions in certain customer contracts, a change in the estimate for medical claims payable does not necessarily result in an equivalent impact on cost of care.

The Company believes that the amount of medical claims payable is adequate to cover its ultimate liability for unpaid claims as of December 31, 2018; however, actual claims payments may differ from established estimates.

Other medical liabilities consist primarily of amounts payable to pharmacies for claims that have been adjudicated by the Company but not yet paid, "reinvestment" payables under certain managed healthcare contracts with Medicaid customers and "profit share" payables under certain risk based contracts. Under a contract with reinvestment features, if the cost of care is less than certain minimum amounts specified in the contract (usually as a percentage of revenue), the Company is required to "reinvest" such difference in behavioral healthcare programs when and as specified by the customer or to pay the difference to the customer for their use in funding such programs. Under a contract with profit share provisions, if the cost of care is below certain specified levels, the Company will "share" the cost savings with the customer at the percentages set forth in the contract. In addition, certain contracts include provisions to provide the Company additional funding if the cost of care is above the specified levels.

Goodwill

The Company is required to test its goodwill for impairment on at least an annual basis. The Company has selected October 1 as the date of its annual impairment test. The goodwill impairment test is a two step process that requires management to make judgments in determining what assumptions to use in the calculation. The first step of the process consists of estimating the fair value of each reporting unit with goodwill based on various valuation techniques, with the primary technique being a discounted cash flow analysis, which requires the input of various assumptions with respect to revenues, operating margins, growth rates and discount rates. The estimated fair value for each reporting unit is compared to the carrying value of the reporting unit, which includes goodwill. If the estimated fair value is less than the carrying value, a second step is performed to compute the amount of the impairment by determining an "implied fair value" of goodwill. The determination of a reporting unit's "implied fair value" of goodwill requires the Company to allocate the estimated fair value of the reporting unit to the assets and liabilities of the reporting unit. Any unallocated fair value represents the "implied fair value" of goodwill, which is compared to its corresponding carrying value.

Goodwill is tested for impairment at a level referred to as a reporting unit. The Company's reporting units with goodwill as of December 31, 2017 were comprised of Commercial, Government and Pharmacy Management. During the third quarter of 2018, the Company re-evaluated how it was managing the Healthcare business segment and decided a reorganization was necessary to effectively manage the business going forward. As a result of this business reorganization, the Company concluded that changes to Healthcare's reporting units were warranted. Healthcare now consists of two reporting units – Behavioral & Specialty Health and Magellan Complete Care ("MCC"). Effective August 1, 2018, the Company evaluated the impact of the reorganization on its previously identified reporting units. The Company allocated goodwill to the new reporting units using a relative fair value approach. In addition, the Company completed an assessment of any potential goodwill impairment for all reporting units immediately prior to and immediately after the reallocation and determined that no impairment existed.

The fair value of Behavioral & Specialty Health (a component of the Healthcare segment), MCC (a component of the Healthcare segment) and Pharmacy Management reporting units were determined using a discounted cash flow method. This method involves estimating the present value of estimated future cash flows utilizing a risk adjusted discount rate. Key assumptions for this method include cash flow projections, terminal growth rates and discount rates.

The 2018 annual goodwill impairment testing as of October 1, 2018, determined that the fair value of the MCC reporting unit had declined, largely due to continued economic challenges in certain markets, and was in excess of its carrying value by a margin of approximately 5%. We considered our observed fourth quarter performance in our October 1, 2018 test. At December 31, 2018, we evaluated whether our forecast for 2019 and beyond would have changed from what was used in our October 1 test. Based on this evaluation, we continue to believe that the fair value of the MCC reporting unit exceeds its carrying value by a margin of approximately 5%. While the reporting unit was not determined to be impaired at this time, the MCC reporting unit goodwill is at risk of future impairment in the event of significant unfavorable changes in the Company's forecasted future results and cash flows. In addition, market factors utilized in the

Table of Contents

impairment analysis, including long-term growth rates or discount rates, could negatively impact the fair value of our reporting units. For testing purposes, management's best estimates of the expected future results are the primary driver in determining the fair value. Fair value determinations require considerable judgment and are sensitive to changes in underlying assumptions and factors. As a result, there can be no assurance that the estimates and assumptions made for purposes of the annual goodwill test will prove to be an accurate prediction of the future.

Examples of events or circumstances that could reasonably be expected to negatively affect the underlying key assumptions and ultimately impact the estimated fair value of our reporting units may include such items as: (i) a decrease in expected future cash flows, specifically, a decrease in membership or rates or customer attrition and increase in costs that could significantly impact our immediate and long-range results, unfavorable working capital changes and an inability to successfully achieve our cost savings targets, (ii) adverse changes in macroeconomic conditions or an economic recovery that significantly differs from our assumptions in timing and/or degree (such as a recession); and (iii) volatility in the equity and debt markets or other country specific factors which could result in a higher weighted-average cost of capital.

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

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

Goodwill for each of the Company’s reporting units with goodwill at December 31, 2017 was as follows (in thousands):

	2017
Commercial	$ 242,255
Government	368,612
Pharmacy Management	395,421
Total	$ 1,006,288

Goodwill for each of the Company’s reporting units with goodwill at December 31, 2018 was as follows (in thousands):

	2018
Behavioral & Specialty Health	$ 410,869
Magellan Complete Care	211,735
Pharmacy Management	395,552
Total	$ 1,018,156

The changes in the carrying amount of goodwill for the years ended December 31, 2017 and 2018 are reflected in the table below (in thousands):

	2017	2018

Balance as of beginning of period	$ 742,054	$ 1,006,288
Acquisition of Veridicus	1,647	—
Acquisition of SWH	260,139	—
Other acquisitions and measurement period adjustments	2,448	11,868
Balance as of end of period	$ 1,006,288	$ 1,018,156

Income Taxes

The Company estimates income taxes for each of the jurisdictions in which it operates. This process involves

determining both permanent and temporary differences resulting from differing treatment for tax and book purposes. Deferred tax assets and/or liabilities are determined by multiplying the temporary differences between the financial reporting and tax reporting bases for assets and liabilities by the enacted tax rates expected to be in effect when such differences are recovered or settled. The Company then assesses the likelihood that the deferred tax assets will be recovered from the reversal of temporary differences, the implementation of feasible and prudent tax planning strategies, and future taxable income. To the extent the Company cannot conclude that recovery is more likely than not, it establishes a valuation allowance. The effect of a change in tax rates on deferred taxes is recognized in income in the period that includes the enactment date.

Determination of the amount of deferred tax assets considered realizable requires significant judgment and estimation regarding the forecasts of future taxable income which are consistent with the plans and estimates the Company uses to manage the underlying businesses. Although consideration is also given to potential tax planning strategies which might be available to improve the realization of deferred tax assets, none were identified which were both prudent and reasonable. Future changes in the estimated realizable portion of deferred tax assets could materially affect the Company’s financial condition and results of operations.

In addition to reducing the federal statutory tax rate from 35% in 2017 to 21% in 2018, the Tax Act that was enacted on December 22, 2017 included a number of other changes to existing U.S. tax laws that impacted the Company, including acceleration of depreciation on certain assets and additional limitations on the deduction of executive compensation. On December 22, 2017, the SEC staff issued Staff Accounting Bulletin No. 118 (“SAB 118”) to address the application of U.S. GAAP in situations when a registrant did not have the necessary information available in reasonable detail to complete the accounting for certain income tax effects of the Tax Act. SAB 118 allowed registrants to determine a reasonable estimate to be included as provisional amounts and provided a measurement period by which the accounting must be completed.

Because the Company had not yet completed its accounting for the effects of the Tax Act at the time, provisional amounts were recorded in 2017 for the enactment-date effects by applying the guidance in SAB 118. The Company has now completed its accounting for all of the enactment-date income tax effects of the Tax Act. As a result, an adjustment of $0.3 million to the provisional amounts is included as a component of income tax expense for 2018.

The tax benefit from an uncertain tax position is recognized when it is more likely than not that, based on the technical merits, the position will be sustained by the taxing authorities upon examination, including resolution of related appeals or litigation processes. Significant judgment is required in determining the Company’s uncertain tax positions. Accruals for uncertain tax positions are established using the Company’s best judgment and adjustments are made, as warranted, due to changing facts and circumstances. The ultimate resolution of a disputed tax position following an examination by a taxing authority could result in a payment that is materially different from that accrued by the Company.

Item 7A. Quantitative and Qualitative Disclosures about Market Risk

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

Item 8. Financial Statements and Supplementary Data

Information with respect to this item is contained in the Company's consolidated financial statements, including the reports of independent accountants, set forth elsewhere herein and financial statement schedule indicated in the Index on Page F 1 of this Report on Form 10 K, and is included herein.

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

None.

Table of Contents

Item 9A. Controls and Procedures

EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

The Company's management evaluated, with the participation of the Company's principal executive and principal financial officers, the effectiveness of the Company's disclosure controls and procedures (as defined in Rules 13a 15(e) and 15d 15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act")), as of December 31, 2018. Based on their evaluation, management has concluded that the Company's disclosure controls and procedures were effective as of December 31, 2018.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

During the year ended December 31, 2017, management completed its initial assessment of the effectiveness of our internal control over financial reporting for our AFSC business, which was acquired on July 1, 2016. During the fourth quarter of fiscal year 2017, we identified and disclosed a material weakness related to inadequate process level controls at AFSC including contract accounting and information technology general controls. Specifically, AFSC did not adequately identify, design and implement appropriate process level controls for its processes, including contract accounting and information technology general controls.

The Company has taken several actions to remediate the material weakness related to our internal control over financial reporting. During the year, we made improvements to the design of the related processes and information technology general controls as well as implemented new controls for each significant process. We added resources to our accounting and financial reporting functions to facilitate the timely execution of the process improvements and to increase the review procedures in numerous areas. With respect to information technology general controls, we have implemented an upgraded software solution to properly account for complex contract terms and designed additional reconciling controls to ensure proper recognition of revenue. As it relates to this software solution, and the existing applications, we developed enhanced procedures and controls related to user access management and changes in information technology systems and implemented a testing plan to monitor information technology general controls with a focus on systems supporting our financial reporting processes. Based on progress made to date as a result of the actions outlined above, we have concluded that the material weakness has been remediated as of December 31, 2018.

In the fourth quarter ended December 31, 2018, there have been no changes in the Company's internal controls over financial reporting that have materially affected, or are reasonably likely to materially affect, the Company's internal controls over financial reporting, except those noted in the preceding paragraph.

MANAGEMENT'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

The Company's management is responsible for establishing and maintaining adequate internal control over financial reporting (as defined in Rule 13a 15(f) under the Securities Exchange Act of 1934, as amended). The Company's internal control system was designed to provide reasonable assurance regarding the preparation and fair presentation of published 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. Under the supervision and with the participation of management, including the Company's Chief Executive Officer and Chief Financial Officer, the Company assessed the effectiveness of internal control over financial reporting as of December 31, 2018. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") in its

statement "Internal Control Integrated Framework (2013)."

Based on this assessment, management has concluded that, as of December 31, 2018, internal control over financial reporting is effective based on these criteria.

The Company's independent registered public accounting firm has issued an audit report on the Company's internal control over financial reporting. This report dated February 28, 2019 appears on page 54 of this Form 10 K.

Table of Contents

Report of Independent Registered Public Accounting Firm

To the Shareholders and Board of Directors of Magellan Health, Inc.

Opinion on Internal Control over Financial Reporting

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

We also have audited in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the accompanying consolidated balance sheets of Magellan Health, Inc. and subsidiaries as of December 31, 2017 and 2018, the related consolidated statements of income, comprehensive income, changes in stockholders' equity and cash flows for each of the three years in the period ended December 31, 2018, and the related notes (collectively referred to as the "financial statements") and our report dated February 28, 2019, expressed an unqualified opinion thereon.

Basis for Opinion

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

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definitions and Limitation 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/ ERNST & YOUNG LLP

Baltimore, Maryland
February 28, 2019

Table of Contents

Item 9B. Other Information

The following information is included in this Item 9B in lieu of filing a Form 8-K:

Entry into a Material Definitive Agreement

Creation of a Direct Financial Obligation or an Obligation under an Off-Balance Sheet Arrangement of a Registrant

On February 27, 2019, Magellan entered into Amendment No. 2 to Credit Agreement (the “Amendment”) with The Bank of Tokyo-Mitsubishi UFJ, Ltd. (“MUFG”), as administrative agent and the lenders party thereto, amending that certain Credit Agreement (as amended by that certain Amendment No. 1 to Credit Agreement, dated as of August 13, 2018, the “2017 Credit Agreement”) dated as of September 22, 2017, among the Magellan, the lenders party thereto, and MUFG as administrative agent. The Amendment amends the 2017 Credit Agreement to modify the financial covenant levels with respect to certain fiscal quarters, beginning with and including the fiscal quarter ended December 31, 2018 and ending on and including the fiscal quarter ending on December 31, 2019, with corresponding modifications to the “leverage covenant holiday” level applicable following “permitted acquisitions” (as such terms are defined in the Amendment or in the 2017 Credit Agreement, as applicable). The foregoing does not constitute a complete summary of the terms of the Amendment and is qualified in its entirety by the full text of the Amendment, a copy of which is filed as Exhibit 4.6 to this Form 10-K and is incorporated by reference herein.

In the ordinary course of their respective businesses, one or more of the lenders, or their affiliates, have or may have various relationships with the Company involving the provision of a variety of financial services, including cash management, commercial banking, investment banking, advisory or other financial services, for which they received, or will receive, customary fees and expenses.

Table of Contents

PART III

The information required by Items 10 through 14 is incorporated by reference to the Registrant's definitive proxy statement to be filed pursuant to Regulation 14A under the Securities Exchange Act of 1934, as amended, within 120 days after December 31, 2018, except for the following information required by Item 10 and Item 12 of this Part III.

The Company will also provide to any person without charge, upon request, copies of its Code of Ethics for Directors, Code of Ethics for Covered Officers, and Corporate Compliance Handbook for all employees (hereinafter referred to as the "Codes of Ethics"). Any such requests should be made in writing to the Investor Relations Department, Magellan Health, Inc., 55 Nod Road, Avon, Connecticut 06001. The Company intends to disclose any future amendments to the provisions of the Codes of Ethics and waivers from such Codes of Ethics, if any, made with respect to any of its directors and executive officers, on its internet site.

Securities Authorized for Issuance under Equity Compensation Plans

The following table sets forth certain information as of December 31, 2018 with respect to the Company's compensation plans under which equity securities are authorized for issuance:

Plan category	Number of securities to be issued upon exercise of outstanding options, warrants and rights (a)		Weighted average exercise price of outstanding options, warrants and rights		Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column(a))	
Equity compensation plans approved by security holders	2,718,378	(1)	$ 68.10	(2)	3,282,964	(3)
Equity compensation plans not approved by security holders	—		—		—	
Total	2,718,378	(1)	$ 68.10	(2)	3,282,964	(3)

(1) Consists of outstanding stock options and unvested restricted stock units and performance-based restricted stock units as of December 31, 2018.
(2) Weighted average exercise price of outstanding stock options as of December 31, 2018.
(3) Consists of shares remaining available for issuance as of December 31, 2018 under the Company's equity compensation plans (pursuant to which the Company may issue stock options, restricted stock awards, stock bonuses, stock purchase rights and other equity incentives), after giving effect to the shares issuable upon the exercise of outstanding options and the shares of restricted stock.

For further discussion, see Note 6—"Stockholders' Equity" to the consolidated financial statements set forth elsewhere herein.

Table of Contents

PART IV

Item 15. Exhibits, Financial Statement Schedule and Additional Information

(a) Documents furnished as part of the Report:
1.Financial Statements

Information with respect to this item is contained on Pages F 1 to F 44 of this Report on Form 10 K.

2.Financial Statement Schedules

Not applicable.

3.Exhibit Index

Exhibit No.	Description of Exhibit
1.1	Underwriting Agreement, dated September 15, 2017, among Magellan Health, Inc., as issuer, and J.P. Morgan Securities LLC, MUFG Securities Americas Inc. and Wells Fargo Securities, LLC, as representatives of the several underwriters named therein, which was filed as Exhibit 1.1 to the Company's current report on Form 8-K, which was filed on September 18, 2017.
2.1	Agreement and Plan of Merger, dated July 13, 2017, among Magellan Healthcare, Inc., SWH Holdings, Inc., certain of the stockholders of SWH Holdings, Inc., certain of the vested optionholders of SWH Holdings, Inc., TA Associates Management, L.P. and Silver Merger Sub, Inc., which was filed as Exhibit 2.1 to the Company's quarterly report on Form 10-Q, which was filed on July 28, 2017 and is incorporated herein by reference.
3.1	Second Amended and Restated Certificate of Incorporation of the Company, as amended and restated on May 25, 2017, which was filed as Exhibit 3.1 to the Company's current report on Form 8-K, which was filed on May 25, 2017 and is incorporated herein by reference.
3.2	Bylaws of the Company as amended and restated on May 24, 2017, which was filed as Exhibit 3.2 to the Company's current report on Form 8-K, which was filed on May 25, 2017 and is incorporated herein by reference.
4.1	Base Indenture, dated as of September 22, 2017, between the Company, as issuer and U.S. Bank National Association, as trustee, which was filed as Exhibit 4.1 to the Company's current report on Form 8-K, which was filed on September 25, 2017.
4.2	First Supplemental Indenture, dated September 22, 2017, between the Company, as issuer and U.S. Bank National Association, as trustee, which was filed as Exhibit 4.2 to the Company's current report on Form 8-K, which was filed on September 25, 2017.
4.3	Form of Global Note for the 4.400% Senior Notes due 2024 (included as an exhibit to Exhibit 4.2), which was filed as Exhibit 4.3 to the Company's current report on Form 8-K, which was filed on September 25, 2017.
4.4	Credit Agreement dated as of September 22, 2017, among the Company, as borrower, BTMU, JPMorgan Chase Bank, N.A., Compass Bank (d/b/a BBVA Compass), U.S. Bank National Association and Wells Fargo Securities, LLC as co-syndication agents, BTMU as administrative agent and the lenders party thereto from time to time, which was filed as Exhibit 4.4 to the Company's current report on Form 8-K, which was filed on September 25, 2017.
4.5	Amendment No.1 to Credit Agreement dated as of August 13, 2018, among the Company, as borrower, The Bank of Tokyo-Mitsubishi UFJ, Ltd., as administrative agent and the lenders party thereto, which was filed as Exhibit 4.1 to the Company's current report on Form 8-K, which was

	filed on August 13, 2018 and is incorporated herein by reference.
#4.6	Amendment No. 2 to Credit Agreement dated as of February 27, 2019, among the Company, as borrower, The Bank of Tokyo-Mitsubishi UFJ, Ltd., as administrative agent and the lenders party thereto.
*10.1	Amended and Restated Supplemental Accumulation Plan, effective as of January 1, 2005, which was filed as Exhibit 10.1 to the Company's Quarterly report on Form 10 Q for the quarter ended September 30, 2006, which was filed on October 26, 2006, and is incorporated herein by reference.

57

Table of Contents

Exhibit No.	Description of Exhibit
*10.2	Magellan Health Services, Inc. 2008 Management Incentive Plan, effective as of May 20, 2008, which was filed as Appendix A to the Company's Definitive Proxy Statement, which was filed on April 11, 2008, and is incorporated herein by reference.
*10.3	Form of Stock Option Agreement, relating to options granted under the Company's 2008 Management Incentive Plan, which was filed as Exhibit 10.1 to the Company's current report on Form 8 K, which was filed on May 27, 2008 and is incorporated herein by reference.
*10.4	Form of Notice of March 2008 Stock Option Grant, relating to options granted under the Company's 2008 Management Incentive Plan, which was filed as Exhibit 10.2 to the Company's current report on Form 8 K, which was filed on May 27, 2008 and is incorporated herein by reference.
*10.5	Employment Agreement, dated August 11, 2008 between the Company and Jonathan Rubin, Chief Financial Officer, which was filed as Exhibit 10.1 to the Company's current report on Form 8 K, which was filed on August 13, 2008, and is incorporated herein by reference.
*10.6	Amendment to Employment Agreement, dated December 1, 2008, between the Company and Daniel N. Gregoire, Executive Vice President, General Counsel and Secretary which was filed as Exhibit 10.58 to the Company's Annual Report on Form 10 K, which was filed on February 27, 2009 and is incorporated herein by reference.
*10.7	Form of Stock Option Agreement, relating to options granted under the Company's 2008 Management Incentive Plan, which was filed as Exhibit 10.1 to the Company's current report on Form 8 K, which was filed on March 10, 2009 and is incorporated herein by reference.
*10.8	Form of Notice of March 2008 Stock Option Grant, relating to options granted under the Company's 2008 Management Incentive Plan, which was filed as Exhibit 10.2 to the Company's current report on Form 8 K, which was filed on March 10, 2009 and is incorporated herein by reference.
*10.9	Form of Stock Option Agreement, relating to options granted under the Company's 2008 Management Incentive Plan, which was filed as Exhibit 10.1 to the Company's current report on Form 8 K, which was filed on March 5, 2010 and is incorporated herein by reference.
*10.10	Form of Notice of March 2008 Stock Option Grant, relating to options granted under the Company's 2008 Management Incentive Plan, which was filed as Exhibit 10.2 to the Company's current report on Form 8 K, which was filed on March 5, 2010 and is incorporated herein by reference.
*10.11	Form of Stock Option Agreement, relating to options granted under the Company's 2008 Management Incentive Plan, which was filed as Exhibit 10.1 to the Company's current report on Form 8 K, which was filed on March 8, 2011 and is incorporated herein by reference.
*10.12	Form of Notice of Stock Option Grant, relating to options granted under the Company's 2008 Management Incentive Plan, which was filed as Exhibit 10.2 to the Company's current report on Form 8 K, which was filed on March 8, 2011 and is incorporated herein by reference.
*10.13	Magellan Health Services, Inc. 2011 Management Incentive Plan, effective as of May 18, 2011, which was filed as Appendix A to the Company's Definitive Proxy Statement, which was filed on April 8, 2011, and is incorporated herein by reference.
*10.14	Form of Stock Option Agreement, relating to options granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.1 to the Company's current report on Form 8 K, which was filed on March 7, 2012 and is incorporated herein by reference.
*10.15	Form of Notice of Stock Option Grant, relating to options granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.2 to the Company's current report on Form 8 K, which was filed on March 7, 2012 and is incorporated herein by reference.
*10.16	Employment Agreement dated December 10, 2012 between the Company and Barry M. Smith, which was filed as Exhibit 10.2 to the Company's current report on Form 8 K, which was filed on December 12, 2012, and is incorporated herein by reference.
*10.17	

	Form of Stock Option Agreement, relating to options granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.1 to the Company's current report on Form 8 K, which was filed on February 7, 2013 and is incorporated herein by reference.
*10.18	Form of Notice of Stock Option Grant, relating to options granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.2 to the Company's current report on Form 8 K, which was filed on February 7, 2013 and is incorporated herein by reference.

58

Table of Contents

Exhibit No.	Description of Exhibit
*10.19	Form of Restricted Stock Unit Agreement, relating to restricted stock units granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.3 to the Company's current report on Form 8 K, which was filed on February 7, 2013 and is incorporated herein by reference.
*10.20	Form of Notice of Restricted Stock Unit Award, relating to restricted stock units granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.4 to the Company's current report on Form 8 K, which was filed on February 7, 2013 and is incorporated herein by reference.
*10.21	Form of Stock Option Agreement, relating to options granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.1 to the Company's current report on Form 8 K, which was filed on March 8, 2013 and is incorporated herein by reference.
*10.22	Form of Notice of Stock Option Grant, relating to options granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.2 to the Company's current report on Form 8 K, which was filed on March 8, 2013 and is incorporated herein by reference.
*10.23	Form of Restricted Stock Unit Agreement, relating to restricted stock units granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.3 to the Company's current report on Form 8 K, which was filed on March 8, 2013 and is incorporated herein by reference.
*10.24	Form of Notice of Restricted Stock Unit Award, relating to restricted stock units granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.4 to the Company's current report on Form 8 K, which was filed on March 8, 2013 and is incorporated herein by reference.
*10.25	Form of Notice of Cash Denominated Award, relating to cash awards granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.5 to the Company's current report on Form 8 K, which was filed on March 8, 2013 and is incorporated herein by reference.
*10.26	Form of Stock Option Agreement, relating to options granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.1 to the Company's current report on Form 8 K, which was filed on March 7, 2014 and is incorporated herein by reference.
*10.27	Form of Notice of Stock Option Grant, relating to options granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.2 to the Company's current report on Form 8 K, which was filed on March 7, 2014 and is incorporated herein by reference.
*10.28	Form of Restricted Stock Unit Agreement, relating to restricted stock units granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.3 to the Company's current report on Form 8 K, which was filed on March 7, 2014 and is incorporated herein by reference.
*10.29	Form of Notice of Restricted Stock Unit Award, relating to restricted stock units granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.4 to the Company's current report on Form 8 K, which was filed on March 7, 2014 and is incorporated herein by reference.
*10.30	Amendment to Employment Agreement, dated April 28, 2014, between the Company and Jonathan N. Rubin, which was filed as Exhibit 10.1 to the Company's current report on Form 8 K, which was filed on April 29, 2014 and is incorporated herein by reference.
*10.31	Employment Agreement, dated September 18, 2013 between the Company and Sam K. Srivastava, Chief Executive Officer of Magellan HealthCare, which was filed as Exhibit 10.85 to the Company's annual report on Form 10 K, which was filed on February 26, 2015 and is incorporated herein by reference.
*10.32	

	Form of Stock Option Agreement, relating to options granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.1 to the Company's current report on Form 8 K, which was filed on March 9, 2015 and is incorporated herein by reference.
*10.33	Form of Notice of Stock Option Grant, relating to options granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.2 to the Company's current report on Form 8 K, which was filed on March 9, 2015 and is incorporated herein by reference.
*10.34	Form of Performance Based Restricted Stock Unit Agreement, relating to performance based restricted stock units granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.3 to the Company's current report on Form 8 K, which was filed on March 9, 2015 and is incorporated herein by reference.
*10.35	Form of Notice of Performance Based Restricted Stock Unit Award, relating to performance based restricted stock units granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.4 to the Company's current report on Form 8 K, which was filed on March 9, 2015 and is incorporated herein by reference.

Table of Contents

Exhibit No.	Description of Exhibit
*10.36	Amendment to Employment Agreement, dated April 28, 2015, between the Company and Jonathan N. Rubin, which was filed as Exhibit 10.1 to the Company's current report on Form 8 K, which was filed on April 29, 2015 and is incorporated herein by reference.
*10.37	Amendment to Employment Agreement, dated October 26, 2015 between the Company and Jonathan N. Rubin, which was filed as Exhibit 10.1 to the Company's quarterly report on Form 10 Q, which was filed on October 27, 2015 and is incorporated herein by reference.
*10.38	Form of Stock Option Agreement, relating to options granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.1 to the Company's current report on Form 8 K, which was filed on March 7, 2016 and is incorporated herein by reference.
*10.39	Form of Notice of Stock Option Grant, relating to options granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.2 to the Company's current report on Form 8 K, which was filed on March 7, 2016 and is incorporated herein by reference.
*10.40	Form of Performance Based Restricted Stock Unit Agreement, relating to performance based restricted stock units granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.3 to the Company's current report on Form 8 K, which was filed on March 7, 2016 and is incorporated herein by reference.
*10.41	Form of Notice of Performance Based Restricted Stock Unit Award, relating to performance based restricted stock units granted under the Company's 2011 Management Incentive Plan, which was filed as Exhibit 10.4 to the Company's current report on Form 8 K, which was filed on March 7, 2016 and is incorporated herein by reference.
*10.42	Magellan Health Services, Inc. 2016 Management Incentive Plan, effective as of May 18, 2016, which was filed as Appendix A to the Company's Definitive Proxy Statement, which was filed on April 8, 2016, and is incorporated herein by reference.
10.43	Share Purchase Agreement dated as of May 15, 2016, among Magellan Health, Inc., Magellan Healthcare, Inc., Armed Forces Services Corporation and the holders of the issued and outstanding common stock of AFSC who are parties thereto, which was filed as Exhibit 10.1 to the Company's quarterly report on Form 10-Q, which was filed on July 29, 2016 and is incorporated herein by reference.
10.44	Purchase Agreement dated as of November 9, 2016, among Magellan Health, Inc., Magellan Pharmacy Solutions, Inc., Veridicus Holdings, LLC and Veridicus Health, LLC, which was filed as Exhibit 10.44 to the Company's annual report on Form 10-K, which was filed on February 24, 2017 and is incorporated herein by reference.
*10.45	Form of Stock Option Agreement, relating to options granted under the Company's 2016 Management Incentive Plan, which was filed as Exhibit 10.1 to the Company's current report on Form 8 K, which was filed on March 8, 2017 and is incorporated herein by reference.
*10.46	Form of Notice of Stock Option Grant, relating to options granted under the Company's 2016 Management Incentive Plan, which was filed as Exhibit 10.2 to the Company's current report on Form 8 K, which was filed on March 7, 2017 and is incorporated herein by reference.
*10.47	Form of Performance-Based Restricted Stock Unit Agreement, relating to performance based restricted stock units granted under the Company's 2016 Management Incentive Plan, which was filed as Exhibit 10.3 to the Company's current report on Form 8 K, which was filed on March 7, 2017 and is incorporated herein by reference.
*10.48	Form of Notice of Performance-Based Restricted Stock Unit Award, relating to performance based restricted stock units granted under the Company's 2016 Management Incentive Plan, which was filed as Exhibit 10.4 to the Company's current report on Form 8 K, which was filed on March 7, 2017 and is incorporated herein by reference.
*10.49	

	Form of Stock Option Agreement, relating to options granted under the 2016 Management Incentive Plan, which was filed as Exhibit 10.1 to the Company's current report on Form 8-K, which was filed on March 9, 2018 and is incorporated herein by reference.
*10.50	Form of Notice of Stock Option Grant, relating to options granted under the 2016 Management Incentive Plan, which was filed as Exhibit 10.2 to the Company's current report on Form 8-K, which was filed on March 9, 2018 and is incorporated herein by reference.

60

Table of Contents

Exhibit No.	Description of Exhibit
*10.51	Form of Performance-Based Restricted Stock Unit Agreement, relating to performance-based restricted stock units granted under the 2016 Management Incentive Plan, which was filed as Exhibit 10.3 to the Company's current report on Form 8-K, which was filed on March 9, 2018 and is incorporated herein by reference.
*10.52	Form of Notice of Performance-Based Restricted Stock Award, relating to performance-based restricted stock units granted under the 2016 Management Incentive Plan, which was filed as Exhibit 10.4 to the Company's current report on Form 8-K, which was filed on March 9, 2018 and is incorporated herein by reference.
#21	List of subsidiaries of the Company.
#23	Consent of Independent Registered Public Accounting Firm.
#31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes Oxley Act of 2002.
#31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes Oxley Act of 2002.
†32.1	Certification of Chief Executive Officer pursuant to Section 906 of the Sarbanes Oxley Act of 2002.
†32.2	Certification of Chief Financial Officer pursuant to Section 906 of the Sarbanes Oxley Act of 2002.
#101	The following materials from the Company's Annual Report on Form 10 K for the fiscal year ended December 31, 2018 formatted in Extensible Business Reporting Language (XBRL): (i) the Consolidated Statements of Income, (ii) the Consolidated Balance Sheets, (iii) the Consolidated Statements of Changes in Shareholders' Equity (iv) the Consolidated Statements of Cash Flows and (v) related notes.

*Constitutes a management contract, compensatory plan or arrangement.

#Filed herewith.

†Furnished herewith.

(b)Exhibits Required by Item 601 of Regulation S K:

Exhibits required to be filed by the Company pursuant to Item 601 of Regulation S K are contained in a separate volume.

(c)Financial statements and schedules required by Regulation S X Rule 12-09:

(1) Not applicable.
(2) Not applicable.
(3) Not applicable.

Item 16. 10-K Summary

None.

Table of Contents

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.

	MAGELLAN HEALTH, INC. (Registrant)
Date: February 28, 2019	/s/ JONATHAN N. RUBIN Jonathan N. Rubin Chief Financial Officer (Principal Financial Officer)
Date: February 28, 2019	/s/ JEFFREY N. WEST Jeffrey N. West Senior Vice President and Controller (Principal Accounting Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, the following persons on behalf of the Registrant and in the capacities and on the dates indicated have signed this Report below.

Signature	Title	Date
/s/ BARRY SMITH Barry Smith	Chief Executive Officer and Chairman of the Board of Directors (Principal Executive Officer)	February 28, 2019
/s/ Swati Abbott Swati Abbott	Director	February 28, 2019
/s/ Dr. John O. Agwunobi Dr. John O. Agwunobi	Director	February 28, 2019
/s/ Eran Broshy Eran Broshy	Director	February 28, 2019
/s/ Michael Diament Michael Diament	Director	February 28, 2019
/s/ Dr. Perry Fine Dr. Perry Fine	Director	February 28, 2019
/s/ G. Scott MacKenzie G. Scott MacKenzie	Director	February 28, 2019
/s/ William J. McBride	Director	February 28, 2019

William J. McBride		
/s/ Matthew J. Simas Matthew J. Simas	Director	February 28, 2019
/s/ JONATHAN N. RUBIN Jonathan N. Rubin	Chief Financial Officer (Principal Financial Officer)	February 28, 2019
/s/ JEFFREY N. WEST Jeffrey N. West	Senior Vice President and Controller (Principal Accounting Officer)	February 28, 2019

Table of Contents

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

INDEX TO FINANCIAL STATEMENTS

The following consolidated financial statements of the registrant and its subsidiaries are submitted herewith in response to Item 8 and Item 15(a)1:

	Page(s)
Magellan Health, Inc.	
Audited Consolidated Financial Statements	
Report of independent registered public accounting firm	F 2
Consolidated balance sheets as of December 31, 2017 and 2018	F 3
Consolidated statements of income for the years ended December 31, 2016, 2017 and 2018	F 4
Consolidated statements of comprehensive income for the years ended December 31, 2016, 2017 and 2018	F 5
Consolidated statements of changes in stockholders' equity for the years ended December 31, 2016, 2017 and 2018	F 6
Consolidated statements of cash flows for the years ended December 31, 2016, 2017 and 2018	F 7
Notes to consolidated financial statements	F 8

All other schedules for which provision is made in the applicable accounting regulation of the Securities and Exchange Commission are not required under the related instructions or are inapplicable and therefore have been omitted.

Table of Contents

Report of Independent Registered Public Accounting Firm

To the Shareholders and Board of Directors of Magellan Health, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Magellan Health, Inc. and subsidiaries as of December 31, 2017 and 2018, the related consolidated statements of income, comprehensive income, changes in stockholders' equity and cash flows for each of the three years in the period ended December 31, 2018, and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, in conformity with 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, 2018, based on the criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated February 28, 2019 expressed an unqualified opinion thereon.

Basis for Opinion

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

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

We have served as the Company's auditor since 2002.

/s/ Ernst & Young LLP

Baltimore, Maryland
February 28, 2019

Table of Contents

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS AS OF DECEMBER 31,

(In thousands, except per share amounts)

	2017	2018
ASSETS		
Current Assets:		
Cash and cash equivalents ($229,013 and $160,967 restricted at December 31, 2017 and December 31, 2018, respectively)	$ 398,732	$ 272,308
Accounts receivable, net	660,775	756,059
Short-term investments ($219,111 and $363,840 restricted at December 31, 2017 and December 31, 2018, respectively)	310,578	382,582
Pharmaceutical inventory	40,945	40,818
Other current assets ($41,121 and $43,401 restricted at December 31, 2017 and December 31, 2018, respectively)	72,323	95,400
Total Current Assets	1,483,353	1,547,167
Property and equipment, net	158,638	150,748
Long-term investments ($17,287 and $2,854 restricted at December 31, 2017 and December 31, 2018, respectively)	17,287	3,161
Deferred income taxes	813	3,411
Other long-term assets	22,567	24,530
Goodwill	1,006,288	1,018,156
Other intangible assets, net	268,288	231,883
Total Assets	$ 2,957,234	$ 2,979,056
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current Liabilities:		
Accounts payable	$ 74,300	$ 72,077
Accrued liabilities	193,635	231,356
Short-term contingent consideration	6,892	8,000
Medical claims payable	327,625	393,547
Other medical liabilities	177,002	169,639
Current debt, capital lease and deferred financing obligations	112,849	24,274
Total Current Liabilities	892,303	898,893
Long-term debt, capital lease and deferred financing obligations	740,888	728,608
Deferred income taxes	12,298	11,167
Tax contingencies	14,226	16,478
Long-term contingent consideration	1,925	2,124
Deferred credits and other long-term liabilities	19,100	36,483
Total Liabilities	1,680,740	1,693,753
Preferred stock, par value $.01 per share Authorized—10,000 shares at December 31, 2017 and December 31, 2018-Issued and outstanding-none	—	—
Common stock, par value $.01 per share Authorized—100,000 shares at December 31, 2017 and December 31, 2018-Issued and outstanding-52,973 and 24,202 shares at December 31, 2017, respectively, and 53,536 and 23,935 shares at	530	535

December 31, 2018, respectively		
Other Stockholders' Equity:		
Additional paid-in capital	1,274,811	1,326,645
Retained earnings	1,399,495	1,419,449
Accumulated other comprehensive loss	(380)	(324)
Treasury stock, at cost, 28,771 and 29,601 shares at December 31, 2017 and December 31, 2018, respectively	(1,397,962)	(1,461,002)
Total Stockholders' Equity	1,276,494	1,285,303
Total Liabilities and Stockholders' Equity	$ 2,957,234	$ 2,979,056

See accompanying notes to consolidated financial statements.

Table of Contents

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME

FOR THE YEARS ENDED DECEMBER 31,

(In thousands, except per share amounts)

	2016	2017	2018
Net revenue:			
Managed care and other	$ 2,902,942	$ 3,479,182	$ 4,878,442
PBM	1,933,942	2,359,401	2,435,709
Total net revenue	4,836,884	5,838,583	7,314,151
Costs and expenses:			
Cost of care	1,882,614	2,413,770	3,762,412
Cost of goods sold	1,818,720	2,211,910	2,283,022
Direct service costs and other operating expenses (1)(2)(3)	876,612	941,883	1,071,535
Depreciation and amortization	106,046	115,706	132,660
Interest expense	10,193	25,977	35,396
Interest and other income	(2,818)	(5,887)	(14,068)
Total costs and expenses	4,691,367	5,703,359	7,270,957
Income before income taxes	145,517	135,224	43,194
Provision for income taxes	69,728	25,083	19,013
Net income	75,789	110,141	24,181
Less: net income (loss) attributable to non-controlling interest	(2,090)	(66)	—
Net income attributable to Magellan	$ 77,879	$ 110,207	$ 24,181
Net income attributable to Magellan per common share:			
Basic (See Note B)	$ 3.36	$ 4.72	$ 0.99
Diluted (See Note B)	$ 3.22	$ 4.51	$ 0.97

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

See accompanying notes to consolidated financial statements.

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

FOR THE YEARS ENDED DECEMBER 31,

(In thousands)

	2016	2017	2018
Net income	$ 75,789	$ 110,141	$ 24,181
Other comprehensive income:			
Unrealized gain (loss) on available-for-sale securities (1)	87	(205)	56
Comprehensive income	75,876	109,936	24,237
Less: comprehensive income (loss) attributable to non-controlling interest	(2,090)	(66)	—
Comprehensive income attributable to Magellan	$ 77,966	$ 110,002	$ 24,237

(1) Net of income tax expense (benefit) of $51, $(8) and $18 for the years ended December 31, 2016, 2017 and 2018, respectively.

See accompanying notes to consolidated financial statements.

Table of Contents

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CHANGES IN STOCKHOLDERS' EQUITY

(In thousands)

	Common Stock		Common Stock In Treasury		Additional Paid in Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total Stockholders Equity
	Shares	Amount	Shares	Amount				
alance at ecember 31, 2015	51,340	$ 513	(26,648)	$ (1,269,391)	$ 1,124,013	$ 1,211,310	$ (262)	$ 1,066,183
ock compensation pense	—	—	—	—	37,422	—	—	37,422
xercise of stock otions	494	6	—	—	24,542	—	—	24,548
djustment due to loption of ASU 016-09	—	—	—	—	—	99	—	99
suance of equity	159	1	—	—	1,229	—	—	1,230
epurchase of stock	—	—	(1,828)	(106,806)	—	—	—	(106,806)
djustment to on-controlling terest	—	—	—	—	(923)	—	—	(923)
et income tributable to agellan	—	—	—	—	—	77,879	—	77,879
ther omprehensive come—other	—	—	—	—	—	—	87	87
alance at ecember 31, 2016	51,993	520	(28,476)	(1,376,197)	1,186,283	1,289,288	(175)	1,099,719
ock compensation pense	—	—	—	—	39,116	—	—	39,116
xercise of stock otions	831	8	—	—	44,347	—	—	44,355
suance of equity	149	2	—	—	361	—	—	363
epurchase of stock	—	—	(295)	(21,765)	—	—	—	(21,765)
djustment to on-controlling terest	—	—	—	—	4,704	—	—	4,704
et income tributable to agellan	—	—	—	—	—	110,207	—	110,207
ther omprehensive ss—other	—	—	—	—	—	—	(205)	(205)
	52,973	530	(28,771)	(1,397,962)	1,274,811	1,399,495	(380)	1,276,494

alance at ecember 31, 2017								
ock compensation pense	—	—	—	—	29,472	—	—	29,472
xercise of stock ptions	409	4	—	—	23,060	—	—	23,064
suance of equity	154	1	—	—	(698)	—	—	(697)
epurchase of stock	—	—	(830)	(63,040)	—	—	—	(63,040)
et income tributable to agellan	—	—	—	—	—	24,181	—	24,181
ther omprehensive come—other	—	—	—	—	—	—	56	56
doption of ASC 06	—	—	—	—	—	(4,227)	—	(4,227)
alance at ecember 31, 2018	53,536	$ 535	(29,601)	$ (1,461,002)	$ 1,326,645	$ 1,419,449	$ (324)	$ 1,285,303

See accompanying notes to consolidated financial statements.

Table of Contents

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS FOR THE YEARS ENDED DECEMBER 31,

(In thousands)

	2016	2017	2018
Cash flows from operating activities:			
Net income	$ 75,789	$ 110,141	$ 24,181
Adjustments to reconcile net income to net cash from operating activities:			
Depreciation and amortization	106,046	115,706	132,660
Non-cash impairment of intangible assets	4,800	—	—
Non-cash interest expense	565	4,757	1,221
Non-cash stock compensation expense	37,422	39,116	29,472
Non-cash income tax provision (benefit)	4,710	(30,981)	(1,725)
Non-cash amortization on investments	5,238	3,924	1,344
Changes in assets and liabilities, net of effects from acquisitions of businesses:			
Accounts receivable, net	(134,089)	(40,910)	(99,295)
Pharmaceutical inventory	(8,246)	17,605	127
Other assets	(13,900)	(4,565)	(25,774)
Accounts payable and accrued liabilities	52,470	(84,445)	9,139
Medical claims payable and other medical liabilities	(8,042)	26,235	72,347
Contingent consideration	(51,205)	696	1,307
Tax contingencies	673	1,681	1,803
Deferred credits and other long-term liabilities	(5,584)	3,218	18,020
Other	52	95	17
Net cash provided by operating activities	66,699	162,273	164,844
Cash flows from investing activities:			
Capital expenditures	(60,881)	(57,232)	(68,275)
Acquisitions and investments in businesses, net of cash acquired	(199,237)	(232,403)	(958)
Purchases of investments	(478,477)	(449,873)	(557,232)
Proceeds from maturities and sales of investments	494,256	423,118	498,032
Net cash used in investing activities	(244,339)	(316,390)	(128,433)
Cash flows from financing activities:			
Proceeds from issuance of debt	375,000	1,041,736	—
Payments to acquire treasury stock	(106,806)	(21,765)	(62,640)
Proceeds from exercise of stock options	25,145	44,355	23,064
Payments on debt, capital lease and deferred financing obligations	(20,891)	(803,393)	(122,239)
Payments on contingent consideration	(40,559)	(3,032)	—
Other	1,230	(9,560)	(1,020)
Net cash provided by (used in) financing activities	233,119	248,341	(162,835)
Net increase (decrease) in cash and cash equivalents	55,479	94,224	(126,424)
Cash and cash equivalents at beginning of period	249,029	304,508	398,732
Cash and cash equivalents at end of period	$ 304,508	$ 398,732	$ 272,308

See accompanying notes to consolidated financial statements.

Table of Contents

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2018

1. General

Basis of Presentation

The consolidated financial statements of Magellan Health, Inc., a Delaware corporation (“Magellan”), include Magellan and its subsidiaries (together with Magellan, the “Company”). All significant intercompany accounts and transactions have been eliminated in consolidation.

Business Overview

The Company is a leader within the healthcare management business, and is focused on delivering innovative specialty solutions for the fastest growing, most complex areas of health, including special populations, complete pharmacy benefits, and other specialty carve-out areas of healthcare. The Company develops innovative solutions that combine advanced analytics, agile technology and clinical excellence to drive better decision making, positively impact members’ health outcomes and optimize the cost of care for the customers we serve. The Company provides services to health plans and other managed care organizations (“MCOs”), employers, labor unions, various military and governmental agencies and third party administrators (“TPAs”). Magellan operates three segments: Healthcare, Pharmacy Management and Corporate.

Healthcare

During the third quarter of 2018, the Company re-evaluated how it was managing the Healthcare business segment and decided a reorganization was necessary to effectively manage the business going forward. As a result of this business reorganization, the Company concluded that changes to Healthcare’s reporting units were warranted. Healthcare now consists of two reporting units – Behavioral & Specialty Health and Magellan Complete Care (“MCC”). Effective August 1, 2018, the Company evaluated the impact of the reorganization on its previously identified reporting units. The Company allocated goodwill to the new reporting units using a relative fair value approach. In addition, the Company completed an assessment of any potential goodwill impairment for all reporting units immediately prior to and immediately after the reallocation and determined that no impairment existed.

The Behavioral & Specialty Health reporting unit’s customers include health plans, accountable care organizations (“ACOs”), employers, the United States military and various federal government agencies for whom Magellan provides carve-out management services for behavioral health, employee assistance plans (“EAP”), and other areas of specialty healthcare including diagnostic imaging, musculoskeletal management, cardiac, and physical medicine. These management services can be applied broadly across commercial, Medicaid and Medicare populations, or on a more targeted basis for our health plans and ACO customers. The Behavioral & Specialty Health unit also includes Magellan’s carve-out behavioral health contracts with various state Medicaid agencies.

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

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

Magellan's coordination and management of these healthcare and long term support services are provided through its comprehensive network of medical and behavioral health professionals, clinics, hospitals, skilled nursing facilities, home care agencies and ancillary service providers. This network of credentialed providers is integrated with clinical and quality improvement programs to improve access to care and enhance the healthcare experience for individuals in need of care, while at the same time making the cost of these services more affordable for our customers.

Table of Contents

The Company generally does not directly provide or own any provider of treatment services, although it does employ licensed behavioral health counselors to deliver non medical counseling under certain government contracts.

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

Pharmacy Management

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

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

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

Corporate

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

2. Summary of Significant Accounting Policies

Recent Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2014-09, "Revenue from Contracts with Customers (Topic 606)" ("ASU 2014-09"). The FASB also issued various ASUs which subsequently amended ASU 2014-09. These amendments and ASU 2014-09, collectively known as Accounting Standard Codification 606 ("ASC 606"), were adopted on a modified retrospective basis in the quarter ended March 31, 2018. The Company applied the standard to contracts not completed at the date of initial application. The Company recognized the cumulative effect of initially applying the new revenue standard as an adjustment to the opening balance of retained earnings. The comparative information has not been restated and continues to be reported under the accounting standards in effect for those periods. For contracts that were modified before January 1, 2018 the Company has not retrospectively restated the contracts for those modifications in accordance with the contract modification guidance, instead the Company reflected the aggregate effect of those modifications when identifying the

satisfied and unsatisfied performance obligations, determining the transaction price and allocating the transaction price to the satisfied and unsatisfied performance obligation. Given the nature of our arrangements, the Company does not believe the use of this practical expedient had a significant impact on the results of our adoption.

A majority of our managed care revenue continues to be recognized over the applicable coverage period on a per member basis for covered members. In addition, a majority of the PBM revenue continues to be recognized as the claims are adjudicated or when the drugs are dispensed. The main impacts of ASC 606 to the Company's business relate to the timing of revenue recognition in relation to upfront fees in certain PBA contracts, as well as performance

Table of Contents

incentive, performance guarantee and risk share arrangements. Some of the Company's PBA contracts contain upfront fees, which under ASC 605 were amortized over the life of the contract. Under ASC 606, these upfront fees constitute a material right and are amortized over the anticipated life of the customer. Certain contracts include performance incentive, performance guarantee and risk share arrangements, which under ASC 605 were recorded based on calculations using the current period's data. Under ASC 606, the revenues are recognized on a probability weighted approach based on anticipated outcomes for the performance period. In addition, under ASC 606 the accounting for material rights in relation to some of the Company's government contracts will impact the consolidated balance sheets for interim reporting periods.

The cumulative effect of changes made to our consolidated January 1, 2018 balance sheet for the adoption of ASU 2014-09 were as follows (in thousands):

	Balance at December 31, 2017	Adjustments Due to ASC 606	Balance at January 1, 2018
Assets			
Other current assets	$ 72,323	$ (667)	$ 71,656
Total Current Assets	1,483,353	(667)	1,482,686
Deferred income taxes	813	1,335	2,148
Other long-term assets	22,567	(1,333)	21,234
Total Assets	2,957,234	(665)	2,956,569
Liabilities and Stockholders' Equity			
Accrued liabilities	193,635	(2,182)	191,453
Total Current Liabilities	892,303	(2,182)	890,121
Deferred credits and other long-term liabilities	19,100	5,744	24,844
Total Liabilities	1,680,740	3,562	1,684,302
Retained earnings	1,399,495	(4,227)	1,395,268
Total Stockholders' Equity	1,276,494	(4,227)	1,272,267
Total Liabilities and Stockholders' Equity	2,957,234	(665)	2,956,569

The impact of the adoption of ASC 606 on our consolidated balance sheet as of December 31, 2018 was as follows (in thousands):

	As Reported	Adjustments	Balance Without ASC 606 Adoption
Assets			
Accounts receivable	$ 756,059	$ (6,210)	$ 749,849
Other current assets	95,400	2,218	97,618

Total Current Assets	1,547,167	(3,992)	1,543,175
Deferred income taxes	3,411	(1,335)	2,076
Other long-term assets	24,530	666	25,196
Total Assets	2,979,056	(4,661)	2,974,395
Liabilities and Stockholders' Equity			
Accrued liabilities	231,356	3,390	234,746
Other medical liabilities	169,639	(165)	169,474
Total Current Liabilities	898,893	3,225	902,118
Deferred credits and other long-term liabilities	36,483	(8,030)	28,453
Total Liabilities	1,693,753	(4,805)	1,688,948
Retained earnings	1,419,449	144	1,419,593
Total Stockholders' Equity	1,285,303	144	1,285,447
Total Liabilities and Stockholders' Equity	2,979,056	(4,661)	2,974,395

Table of Contents

The impact of the adoption of ASC 606 on our consolidated income statement for the year ended December 31, 2018 was as follows (in thousands):

	As Reported	Adjustments	Balance Without ASC 606 Adoption
Managed care and other	$ 4,878,442	$ (5,634)	$ 4,872,808
Total net revenue	7,314,151	(5,634)	7,308,517
Income before income taxes	43,194	(5,634)	37,560
Provision for income taxes	19,013	(1,551)	17,462
Net income	24,181	(4,083)	20,098
Net income attributable to Magellan	24,181	(4,083)	20,098

In February 2016, the FASB issued ASU No. 2016 02, "Leases" ("ASU 2016 02"). This ASU amends the existing accounting standards for lease accounting, including requiring lessees to recognize most leases on their balance sheets. The FASB also issued various ASUs which subsequently amended ASU 2016-02. These amendments and ASU 2016-02, collectively known as Accounting Standard Codification 842 ("ASC 842"), are effective for annual and interim reporting periods of public entities beginning after December 15, 2018, with early adoption permitted. The Company adopted the new standard on a modified retrospective basis and apply the transition method which did not require adjustments to comparative periods nor require modified disclosures in those comparative periods. The Company implemented new leasing software capable of producing the data to prepare the required accounting and disclosures prescribed by ASC 842. The Company is still assessing the impact of this ASU, but anticipates the adoption of this ASU will result in the recognition of right-of-use assets and lease liabilities of approximately $45 million to $65 million. The Company does not anticipate the adoption of this ASU will have a material impact on the Company's consolidated results of operations.

In June 2016, the FASB issued ASU No. 2016-13, "Financial Instruments-Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments" ("ASU 2016-13"). This ASU amends the accounting on reporting credit losses for assets held at amortized cost basis and available for sale debt securities. This guidance is effective for annual and interim periods of public entities beginning after December 15, 2019, with early adoption permitted for fiscal years beginning after December 31, 2018. The Company is currently assessing the potential impact this ASU will have on the Company's consolidated results of operation, financial position and cash flows.

In January 2017, the FASB issued ASU No. 2017-04, "Intangibles-Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment" ("ASU 2017-04"). The amendments in this ASU eliminate the requirement to calculate the implied fair value of goodwill to measure a goodwill impairment charge. This guidance is effective for annual and interim periods of public entities beginning after December 15, 2019, with early adoption permitted. The Company is currently assessing the potential impact this ASU will have on the Company's consolidated results of operations, financial position and cash flows.

In August 2018, the FASB issued ASU No. 2018-15, "Intangibles-Goodwill and Other–Internal-Use Software (Subtopic 350-40): Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract" ("ASU 2018-15"). This ASU aligns the requirements for capitalizing implementation costs incurred in

a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. This guidance is effective for annual and interim periods of public entities beginning after December 15, 2019, with early adoption permitted. The Company is currently assessing the potential impact this ASU will have on the Company's consolidated results of operations, financial position and cash flows.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates of the Company can include, among other things, valuation of goodwill and intangible assets, medical claims payable, other medical liabilities, stock compensation assumptions, tax contingencies and legal liabilities. In addition, the Company also makes estimates in

Table of Contents

relation to revenue recognition under ASC 606 which are explained in more detail in "Revenue Recognition" below. Actual results could differ from those estimates.

Revenue Recognition

Virtually all of the Company's revenues are derived from business in North America. The following tables disaggregate our revenue for the year ended December 31, 2018 by major service line, type of customer and timing of revenue recognition (in thousands):

	Year Ended December 31, 2018			
	Healthcare	Pharmacy Management	Elimination	Total
Major Service Lines				
Behavioral & Specialty Health				
Risk-based, non-EAP	$ 1,511,532	$ —	$ (263)	$ 1,511,269
EAP risk-based	349,751	—	—	349,751
ASO	247,953	34,130	(344)	281,739
Magellan Complete Care				
Risk-based, non-EAP	2,473,570	—	—	2,473,570
ASO	55,816	—	—	55,816
PBM, including dispensing	—	2,183,151	(189,708)	1,993,443
Medicare Part D	—	442,266	—	442,266
PBA	—	132,112	—	132,112
Formulary management	—	70,900	—	70,900
Other	—	3,285	—	3,285
Total net revenue	$ 4,638,622	$ 2,865,844	$ (190,315)	$ 7,314,151
Type of Customer				
Government	$ 3,432,901	$ 946,606	$ —	$ 4,379,507
Non-government	1,205,721	1,919,238	(190,315)	2,934,644
Total net revenue	$ 4,638,622	$ 2,865,844	$ (190,315)	$ 7,314,151
Timing of Revenue Recognition				
Transferred at a point in time	$ —	$ 2,625,417	$ (189,708)	$ 2,435,709
Transferred over time	4,638,622	240,427	(607)	4,878,442
Total net revenue	$ 4,638,622	$ 2,865,844	$ (190,315)	$ 7,314,151

Per Member Per Month ("PMPM") Revenue. Almost all of the Healthcare revenue and a small portion of the Pharmacy Management revenue is paid on a PMPM basis. PMPM revenue is inclusive of revenue from the Company's risk, EAP and ASO contracts and primarily relates to managed care contracts for services such as the provision of behavioral healthcare, specialty healthcare, pharmacy management, or fully integrated healthcare services. PMPM contracts generally have a term of one year or longer, with the exception of government contracts where the customer can terminate with as little as 30 days' notice for no significant penalty. All managed care contracts have a single performance obligation that constitutes a series for the provision of managed healthcare services for a population of enrolled members for the duration of the contract. The transaction price for PMPM contracts is entirely variable as it primarily includes per member per month fees associated with unspecified membership that fluctuates throughout the contract. In certain contracts, PMPM fees also include variable consideration for things such as performance

incentives, performance guarantees, risk pool measures and risk shares. The Company generally estimates the transaction price using an expected value methodology and amounts are only included in the net transaction price to the extent that it is probable that a significant reversal of cumulative revenue will not occur once any uncertainty is resolved. The majority of the Company's net PMPM transaction price relates specifically to its efforts to transfer the service for a distinct increment of the series (e.g. day or month) and is recognized as revenue in the month in which members are entitled to service. The remaining transaction price is recognized over the contract period (or portion of the series to which it specifically relates) based upon estimated membership as a measure of progress.

Under certain government contracts, our rates are subject to subsequent retroactive adjustment for things such

as risk pool measures. In determining the adjustment necessary for various items, certain measures are compared with the relevant state and market pool. The adjustments are determined annually or semi-annually on a retrospective basis. Generally, if we are below the average, we are required to make a payment into the pool, and if we are above the average, we will receive a payment from the pool from these adjustments. These adjustments can have a positive or negative retroactive impact to rates. The adjustments to our rates are considered variable consideration and are estimated on a quarterly basis using an expected value method. Amounts of variable consideration are recognized as revenue only to the extent it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the variable consideration is subsequently resolved.

Pharmacy Benefit Management Revenue. The Company's customers for PBM business, including pharmaceutical dispensing operations, are generally comprised of MCOs, employer groups and health plans. PBM relationships generally have an expected term of one year or longer. A master services arrangement ("MSA") is executed by the Company and the customer, which outlines the terms and conditions of the PBM services to be provided. When a member in the customer's organization submits a prescription, a claim is created which is presented for approval. The acceptance of each individual claim creates enforceable rights and obligations for each party and represents a separate contract. For each individual claim, the performance obligations are limited to the processing and adjudication of the claim, or dispensing of the products purchased. Generally, the transaction price for PBM services is explicitly listed in each contract and does not represent variable consideration. The Company recognizes PBM revenue, which consists of a negotiated prescription price (ingredient cost plus dispensing fee), co payments and any associated administrative fees, when claims are adjudicated or the drugs are shipped. The Company recognizes PBM revenue on a gross basis (i.e. including drug costs and co payments) as it is acting as the principal in the arrangement, controls the underlying service, and is contractually obligated to its clients and network pharmacies, which is a primary indicator of gross reporting. In addition, the Company is solely responsible for the claims adjudication process, negotiating the prescription price for the pharmacy, collection of payments from the client for drugs dispensed by the pharmacy, and managing the total prescription drug relationship with the client's members. If the Company enters into a contract where it is only an administrator, and does not assume any of the risks previously noted, revenue will be recognized on a net basis. For dispensing, at the time of shipment, the earnings process is complete; the obligation of the Company's customer to pay for the specialty pharmaceutical drugs is fixed, and, due to the nature of the product, the member may neither return the specialty pharmaceutical drugs nor receive a refund.

Medicare Part D. The Company is contracted with CMS as a Prescription Drug Plan ("PDP") to provide prescription drug benefits to Medicare beneficiaries. The accounting for Medicare Part D revenue is primarily the same as that for PBM, as previously discussed. However, there is certain variable consideration present only in Medicare Part D arrangements. The Company estimates the annual amount of variable consideration using a most likely amount methodology, which is allocated to each reporting period based upon actual utilization as a percentage of estimated utilization for the year. Amounts estimated throughout the year for interim reporting are substantially resolved and fixed as of December 31st, the end of the plan year.

Pharmacy Benefit Administration Revenue. The Company provides Medicaid pharmacy services to states and other government sponsored programs. PBA contracts are generally multi-year arrangements but include language regarding early termination for convenience without material penalty provisions that results in enforceable rights and obligations on a month-to-month basis. In PBA arrangements, the Company is generally paid a fixed fee per month to provide PBA services. In addition, some PBA contracts contain upfront fees that constitute a material right. For contracts without an upfront fee, there is a single performance obligation to stand ready to provide the PBA services required for the contracted period. The Company believes that the customer receives the PBA benefits each day from access to the claims processing activities, and has concluded that a time based measure is appropriate for recognizing PBA revenue. For contracts with an upfront fee, the material right represents an additional performance obligation.

Amounts allocated to the material right are initially recorded as a contract liability and recognized as revenue over the anticipated period of benefit of the material right, which generally ranges from 2 to 10 years.

Formulary Management Revenue. The Company administers formulary management programs for certain clients through which the Company coordinates the achievement, calculation and collection of rebates and administrative fees from pharmaceutical manufacturers on behalf of clients. Formulary management contracts generally have a term of one year or longer. All formulary management contracts have a single performance obligation that constitutes a series for the provision of rebate services for a drug, with utilization measured and settled on a quarterly basis, for the duration of the arrangement. The Company retains its administrative fee and/or a percentage of rebates that is included in its contract with the client from collecting the rebate from the manufacturer. While the administrative fee and/or the percentage of

Table of Contents

rebates retained is fixed, there is an unknown quantity of pharmaceutical purchases (utilization) during each quarter, therefore the transaction price itself is variable. The Company uses the expected value methodology to estimate the total rebates earned each quarter based on estimated volumes of pharmaceutical purchases by the Company's clients during the quarter, as well as historical and/or anticipated retained rebate percentages. The Company does not record as rebate revenue any rebates that are passed through to its clients.

In relation to the Company's PBM business, the Company administers rebate programs through which it receives rebates from pharmaceutical manufacturers that are shared with its customers. The Company recognizes rebates when the Company is entitled to them and when the amounts of the rebates are determinable. The amount recorded for rebates earned by the Company from the pharmaceutical manufacturers is recorded as a reduction of cost of goods sold.

Government EAP Risk-Based Revenue. The Company has certain contracts with federal customers for the provision of various managed care services, which are classified as EAP risk-based business. These contracts are generally multi-year arrangements. The Company's federal contracts are reimbursed on either a fixed fee basis or a cost reimbursement basis. The performance obligation on a fixed fee contract is to stand ready to provide the staffing required for the contracted period. For fixed fee contracts, the Company believes the invoiced amount corresponds directly with the value to the customer of the Company's performance completed to date, therefore the Company is utilizing the "right to invoice" practical expedient, with revenue recognition in the amount for which the Company has the right to invoice.

The performance obligation on a cost reimbursement contract is to stand ready to provide the activity or services purchased by the customer, such as the operation of a counseling services group or call center. The performance obligation represents a series for the duration of the arrangement. The reimbursement rate is fixed per the contract, however the level of activity (e.g., number of hours, number of counselors or number of units) is variable. A majority of the Company's cost reimbursement transaction price relates specifically to its efforts to transfer the service for a distinct increment of the series (e.g. day or month) and is recognized as revenue when the portion of the series for which it relates has been provided (i.e. as the Company provides hours, counselors or units of service).

In accordance with ASC 606-10-50-13, the Company is required to include disclosure on its remaining performance obligations as of the end of the current reporting period. Due to the nature of the contracts in the Company's PBM and Part D business, these reporting requirements are not applicable. The majority of the Company's remaining contracts meet certain exemptions as defined in ASC 606-10-50-14 through 606-10-50-14A, including (i) performance obligation is part of a contract that has an original expected duration of one year or less; (ii) the right to invoice practical expedient; and (iii) variable consideration related to unsatisfied performance obligations that is allocated entirely to a wholly unsatisfied promise to transfer a distinct service that forms part of a single performance obligation, and the terms of that variable consideration relate specifically to our efforts to transfer the distinct service, or to a specific outcome from transferring the distinct service. For the Company's contracts that pertain to these exemptions: (i) the remaining performance obligations primarily relate to the provision of managed healthcare services to the customers' membership; (ii) the estimated remaining duration of these performance obligations ranges from the remainder of the current calendar year to three years; and (iii) variable consideration for these contracts primarily includes net per member per month fees associated with unspecified membership that fluctuates throughout the contract.

Accounts Receivable, Contract Assets and Contract Liabilities

Accounts receivable, contract assets and contract liabilities consisted of the following (in thousands, except percentages):

	January 1, 2018	December 31, 2018	$ Change	% Change
Accounts receivable	$ 679,269	$ 786,395	$ 107,126	15.8%
Contract assets	8,564	4,647	(3,917)	(45.7%)
Contract liabilities - current	14,299	16,853	2,554	17.9%
Contract liabilities - long-term	12,303	13,441	1,138	9.2%

Accounts receivable, which are included in accounts receivable, other current assets and other long-term assets on the consolidated balance sheets, increased by $107.1 million, mainly due to timing. Contract assets, which are included in other current assets on the consolidated balance sheets, decreased by $3.9 million, mainly due to the timing

Table of Contents

of accrual of certain performance incentives. Contract liabilities – current, which are included in accrued liabilities on the consolidated balance sheets, increased by $2.6 million, mainly due to the timing of receipts related to January 2019 revenues. Contract liabilities – long-term, which are included in deferred credits and other long-term liabilities on the consolidated balance sheets, increased by $1.1 million, mainly due to receipts for which recognition will be long-term.

During the year ended December 31, 2018, the Company recognized revenue of $14.1 million that was included in current contract liabilities at January 1, 2018. The estimated timing of recognition of amounts included in contract liabilities at December 31, 2018 are as follows: 2019—$16.9 million; 2020—$3.4 million; 2021—$2.9 million; 2022 and beyond—$7.1 million. During the year ended December 31, 2018, the Company recognized revenue of $14.4 million for one customer that was related to performance obligations that were satisfied, or partially satisfied, in previous periods. During the year, all other revenue that the Company recognized related to performance obligations that were satisfied, or partially satisfied, in previous periods was not material.

The Company's accounts receivable consists of amounts due from customers throughout the United States. Collateral is generally not required. A majority of the Company's contracts have payment terms in the month of service, or within a few months thereafter. The timing of payments from customers from time to time generate contract assets or contract liabilities, however these amounts are immaterial.

Significant Customers

Customers exceeding ten percent of the consolidated Company's net revenues

The Company has a contract with the State of Florida to provide integrated healthcare services to Medicaid enrollees in the state of Florida (the "Florida Contract"). The Florida Contract began on February 4, 2014 and extends through December 31, 2018, unless sooner terminated by the parties. Under the Florida Contract, the Company serves all of the members in the Florida Agency for Health Care Administration ("AHCA") Regions 2, 4, 5, 6, 7, 9, 10, and 11. The State of Florida has the right to terminate the Florida Contract with cause, as defined, upon 24 hour notice and upon 30 days notice for any reason or no reason at all. The Florida Contract generated net revenues of $548.7 million, $605.9 million and $618.2 million for the years ended December 31, 2016, 2017 and 2018, respectively.

On July 14, 2017, the State of Florida issued an Invitation to Negotiate for a new contract for its Medicaid managed care program to replace the current contract with the Company and to be effective January 1, 2019. On April 24, 2018 the Company was notified by AHCA that the Company was not selected to negotiate a new contract to serve as a vendor for its Medicaid managed care program. The Company filed a protest with AHCA on May 7 2018. On August 30, 2018, the Company entered into a settlement with AHCA in regards to the Company's protest. Pursuant to the terms of the settlement, Florida MHS, Inc. d/b/a Magellan Complete Care of Florida was awarded a contract extending through September 30, 2023 to serve Medicaid members with SMI in AHCA Regions 4, 5, and 7 alongside another vendor. The Company will no longer serve members in Regions 2, 6, 9, 10, and 11, which represents approximately 60% of the total current membership the Company serves under the existing Florida Contract. On September 4, 2018, the Company withdrew its protest under the terms of the settlement agreement.

Table of Contents

Customers exceeding ten percent of segment net revenues

In addition to the Florida Contract previously discussed, the following customers generated in excess of ten percent of net revenues for the respective segment for the years ended December 31, 2016, 2017 and 2018 (in thousands):

Segment	Term Date	2016		2017		2018	
Healthcare							
Customer A	(1)	$ 138,966	*	$ 265,192	*	$ 691,616	
Customer B	December 31, 2019 to December 31, 2020 (2)	—		109,049	*	682,059	
Customer C	December 31, 2022	—		73,758	*	476,671	
Pharmacy Management							
Customer D	March 31, 2020	152,218	*	346,405		344,479	
Customer E	December 31, 2016 (3)	264,152		4,764	*	2,864	*

* Revenue amount did not exceed 10 percent of net revenues for the respective segment for the year presented. Amount is shown for comparative purposes only.

(1) The Company, along with other participating managed care plans in this state, continues to provide services while a new contract is being finalized.
(2) The customer has more than one contract. The individual contracts are scheduled to terminate at various points during the time period indicated above.
(3) A vast majority of this customer's revenues were generated from drug acquisition costs related to PBM services which terminated on September 1, 2016. The Company continues to provide specialty drug formulary management services to the customer and is in negotiations with the customer to extend the contract.

Concentration of Business

The Company also has a significant concentration of business with various counties in the State of Pennsylvania (the "Pennsylvania Counties") which are part of the Pennsylvania Medicaid program, with members under its contract with CMS and with various agencies and departments of the United States federal government. Net revenues from the Pennsylvania Counties in the aggregate totaled $461.6 million, $490.0 million and $544.6 million for the years ended December 31, 2016, 2017 and 2018, respectively. Net revenues from members in relation to its contract with CMS in aggregate totaled $272.8 million, $511.0 million and $442.3 million for the years ended December 31, 2016, 2017 and 2018, respectively. Net revenues from contracts with various agencies and departments of the United States federal government in aggregate totaled $252.5 million, $341.5 million, and $308.7 million for the years ended December 31, 2016, 2017 and 2018, respectively.

The Company's contracts with customers typically have stated terms of one to three years, and in certain cases contain renewal provisions (at the customer's option) for successive terms of between one and two years (unless terminated earlier). Substantially all of these contracts may be immediately terminated with cause and many of the Company's contracts are terminable without cause by the customer or the Company either upon the giving of requisite notice and the passage of a specified period of time (typically between 30 and 180 days) or upon the occurrence of other specified events. In addition, the Company's contracts with federal, state and local governmental agencies generally are conditioned on legislative appropriations. These contracts generally can be terminated or modified by the customer if such appropriations are not made.

Income Taxes

The Company files a consolidated federal income tax return with its eighty-percent or more controlled subsidiaries. The Company previously filed separate consolidated federal income tax returns for AlphaCare of New York, Inc. (“AlphaCare”) and its parent, AlphaCare Holdings, Inc. (“AlphaCare Holdings”). During 2017, AlphaCare and AlphaCare Holdings became members of the Magellan federal consolidated group. The Company and its

Table of Contents

subsidiaries also file income tax returns in various state and local jurisdictions.

The Company estimates income taxes for each of the jurisdictions in which it operates. This process involves determining both permanent and temporary differences resulting from differing treatment for tax and book purposes. Deferred tax assets and/or liabilities are determined by multiplying the temporary differences between the financial reporting and tax reporting bases for assets and liabilities by the enacted tax rates expected to be in effect when such differences are recovered or settled. The Company then assesses the likelihood that the deferred tax assets will be recovered from the reversal of temporary differences, the implementation of feasible and prudent tax planning strategies, and future taxable income. To the extent the Company cannot conclude that recovery is more likely than not, it establishes a valuation allowance. The effect of a change in tax rates on deferred taxes is recognized in income in the period that includes the enactment date. Reversals of both valuation allowances and unrecognized tax benefits are recorded in the period they occur, typically as reductions to income tax expense.

The Company recognizes interim period income taxes by estimating an annual effective tax rate and applying it to year to date results. The estimated annual effective tax rate is periodically updated throughout the year based on actual results to date and an updated projection of full year income. Although the effective tax rate approach is generally used for interim periods, taxes on significant, unusual and infrequent items are recognized at the statutory tax rate entirely in the period the amounts are realized.

Health Care Reform

The Patient Protection and the Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the “Health Reform Law”), imposes a mandatory annual fee on health insurers for each calendar year beginning on or after January 1, 2014. The Company has obtained rate adjustments from customers which the Company expects will cover the direct costs of these fees and the impact from non deductibility of such fees for federal and state income tax purposes. To the extent the Company has such a customer that does not renew, there may be some impact due to taxes paid where the timing and amount of recoupment of these additional costs is uncertain. In the event the Company is unable to obtain rate adjustments to cover the financial impact of the annual fee, the fee may have a material impact on the Company. The Consolidated Appropriations Act of 2016 imposed a one-year moratorium on the Patient Protection and Affordable Care Act health insurer fee (“HIF”) fee, suspending its application for 2017. The HIF fee went back into effect for 2018, however, on January 23, 2018 the United States Congress passed the Continuing Resolution which imposed another one-year moratorium on the HIF fee, suspending its application for 2019. For 2016 and 2018, the HIF fees were $26.5 million and $29.9 million, respectively, which have been paid and which are included in direct service costs and other operating expenses in the consolidated statements of income.

Cash and Cash Equivalents

Cash equivalents are short term, highly liquid interest bearing investments with maturity dates of three months or less when purchased, consisting primarily of money market instruments. At December 31, 2018, the Company’s excess capital and undistributed earnings for the Company’s regulated subsidiaries of $63.3 million are included in cash and cash equivalents.

Restricted Assets

The Company has certain assets which are considered restricted for: (i) the payment of claims under the terms of certain managed care contracts; (ii) regulatory purposes related to the payment of claims in certain jurisdictions; and (iii) the maintenance of minimum required tangible net equity levels for certain of the Company’s subsidiaries. Significant restricted assets of the Company as of December 31, 2017 and 2018 were as follows (in thousands):

	2017	2018
Restricted cash and cash equivalents	$ 229,013	$ 160,967
Restricted short-term investments	219,111	363,840
Restricted deposits (included in other current assets)	41,121	43,401
Restricted long-term investments	17,287	2,854
Total	$ 506,532	$ 571,062

The Company’s equity in restricted net assets of consolidated subsidiaries represented approximately 24.6% of

Table of Contents

the Company's consolidated stockholder's equity as of December 31, 2018 and consisted of net assets of the Company which were restricted as to transfer to Magellan in the form of cash dividends, loans or advances under regulatory restrictions.

Fair Value Measurements

The Company has certain assets and liabilities that are required to be measured at fair value on a recurring basis. These assets and liabilities are to be measured using inputs from the three levels of the fair value hierarchy, which are as follows:

Level 1—Inputs are unadjusted quoted prices in active markets for identical assets or liabilities that the Company has the ability to access at the measurement date.

Level 2—Inputs include quoted prices for similar assets and liabilities in active markets, quoted prices for identical or similar assets or liabilities in markets that are not active, inputs other than quoted prices that are observable for the asset or liability (i.e., interest rates, yield curves, etc.), and inputs that are derived principally from or corroborated by observable market data by correlation or other means (market corroborated inputs).

Level 3—Unobservable inputs that reflect the Company's assumptions about the assumptions that market participants would use in pricing the asset or liability. The Company develops these inputs based on the best information available, including the Company's data.

In accordance with the fair value hierarchy described above, the following table shows the fair value of the Company's financial assets and liabilities that are required to be measured at fair value as of December 31, 2017 and 2018 (in thousands):

	December 31, 2017			
	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents (1)	$ —	$ 284,064	$ —	$ 284,064
Investments:				
U.S. Government and agency securities	28,231	—	—	28,231
Obligations of government-sponsored enterprises (2)	—	22,088	—	22,088
Corporate debt securities	—	269,788	—	269,788
Taxable municipal bonds	—	5,000	—	5,000
Certificates of deposit	—	2,758	—	2,758
Total assets held at fair value	$ 28,231	$ 583,698	$ —	$ 611,929
Liabilities				
Contingent consideration	$ —	$ —	$ 8,817	$ 8,817
Total liabilities held at fair value	$ —	$ —	$ 8,817	$ 8,817

	December 31, 2018			
	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents (3)	$ —	$ 263,462	$ —	$ 263,462

Investments:				
U.S. Government and agency securities	67,815	—	—	67,815
Obligations of government-sponsored enterprises (2)	—	5,229	—	5,229
Corporate debt securities	—	292,049	—	292,049
Certificates of deposit	—	20,650	—	20,650
Total assets held at fair value	$ 67,815	$ 581,390	$ —	$ 649,205
Liabilities				
Contingent consideration	$ —	$ —	$ 10,124	$ 10,124
Total liabilities held at fair value	$ —	$ —	$ 10,124	$ 10,124

Table of Contents

(1) Excludes $114.7 million of cash held in bank accounts by the Company.
(2) Includes investments in notes issued by the Federal Home Loan Bank, Federal Farm Credit Banks and Federal National Mortgage Association.
(3) Excludes $8.8 million of cash held in bank accounts by the Company.

For the years ended December 31, 2017 and 2018, the Company did not transfer any assets between fair value measurement levels.

The carrying values of financial instruments, including accounts receivable and accounts payable, approximate their fair values due to their short-term maturities. The fair value of the Notes (as defined below) of $370.1 million as of December 31, 2018 was determined based on quoted market prices and would be classified within Level 1 of the fair value hierarchy. The estimated fair value of the Company's term loan of $328.1 million as of December 31, 2018 was based on current interest rates for similar types of borrowings and is in Level 2 of the fair value hierarchy. The estimated fair values may not represent actual values of the financial instruments that could be realized as of the balance sheet date or that will be realized in the future.

All of the Company's investments are classified as "available-for-sale" and are carried at fair value.

As of the balance sheet date, the fair value of contingent consideration is determined based on probabilities of payment, projected payment dates, discount rates, projected operating income, member engagement and new contract execution. The Company used a probability weighted discounted cash flow method to arrive at the fair value of the contingent consideration. As the fair value measurement for the contingent consideration is based on inputs not observed in the market, these measurements are classified as Level 3 measurements as defined by fair value measurement guidance. The unobservable inputs used in the fair value measurement include the discount rate, probabilities of payment and projected payment dates.

As of December 31, 2017 and 2018, the Company estimated undiscounted future contingent payments of $9.9 million and $10.6 million, respectively. As of December 31, 2018, the aggregate amounts and projected dates of future potential contingent consideration payments were $8.0 million in 2019 and $2.6 million in 2020.

As of December 31, 2017, the fair value of the short-term and long-term contingent consideration was $6.9 million and $1.9 million, respectively, and is included in short-term contingent consideration and long-term contingent consideration, respectively, in the consolidated balance sheets. As of December 31, 2018, the fair value of the short-term and long-term contingent consideration was $8.0 million and $2.1 million, respectively, and is included in short-term contingent consideration and long-term contingent consideration, respectively, in the consolidated balance sheets.

The change in the fair value of the contingent consideration was $(0.1) million, $0.7 million and $1.3 million for the years ended December 31, 2016, 2017 and 2018, respectively, which were recorded as direct service costs and other operating expenses in the consolidated statements of income. The increases during 2018 were mainly a result of changes in present value and the estimated undiscounted liability.

The following table summarizes the Company's liability for contingent consideration (in thousands):

	December 31, 2017	December 31, 2018
Balance as of beginning of period	$ 11,153	$ 8,817
Changes in fair value	696	1,307
Payments	(3,032)	—

Balance as of end of period	$ 8,817	$ 10,124

Investments

All of the Company’s investments are classified as “available for sale” and are carried at fair value. Securities which have been classified as Level 1 are measured using quoted market prices in active markets for identical assets or liabilities while those which have been classified as Level 2 are measured using quoted prices for identical assets and

Table of Contents

liabilities in markets that are not active. The Company's policy is to classify all investments with contractual maturities within one year as current. Investment income is recognized when earned and reported net of investment expenses. Net unrealized holding gains or losses are excluded from earnings and are reported, net of tax, as "accumulated other comprehensive income (loss)" in the accompanying consolidated balance sheets and consolidated statements of comprehensive income until realized, unless the losses are deemed to be other than temporary. Realized gains or losses, including any provision for other than temporary declines in value, are included in the consolidated statements of income.

If a debt security is in an unrealized loss position and the Company has the intent to sell the debt security, or it is more likely than not that the Company will have to sell the debt security before recovery of its amortized cost basis, the decline in value is deemed to be other than temporary and is recorded to other than temporary impairment losses recognized in income in the consolidated statements of income. For impaired debt securities that the Company does not intend to sell or it is more likely than not that the Company will not have to sell such securities, but the Company expects that it will not fully recover the amortized cost basis, the credit component of the other than temporary impairment is recognized in other than temporary impairment losses recognized in income in the consolidated statements of income and the non credit component of the other than temporary impairment is recognized in other comprehensive income.

The credit component of an other than temporary impairment is determined by comparing the net present value of projected future cash flows with the amortized cost basis of the debt security. The net present value is calculated by discounting the best estimate of projected future cash flows at the effective interest rate implicit in the debt security at the date of acquisition. Cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings, and estimates regarding timing and amount of recoveries associated with a default. Furthermore, unrealized losses entirely caused by non credit related factors related to debt securities for which the Company expects to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive income.

As of December 31, 2017 and 2018, there were no material unrealized losses that the Company believed to be other than temporary. No realized gains or losses were recorded for the years ended December 31, 2016, 2017, or 2018. The following is a summary of short-term and long-term investments at December 31, 2017 and 2018 (in thousands):

	December 31, 2017			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U.S. Government and agency securities	$ 28,313	$ —	$ (82)	$ 28,231
Obligations of government-sponsored enterprises (1)	22,139	—	(51)	22,088
Corporate debt securities	270,154	1	(367)	269,788
Taxable municipal bonds	5,000	—	—	5,000
Certificates of deposit	2,758	—	—	2,758
Total investments at December 31, 2017	$ 328,364	$ 1	$ (500)	$ 327,865

	December 31, 2018			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value

U.S. Government and agency securities	$ 67,870	$ 17	$ (72)	$ 67,815
Obligations of government-sponsored enterprises (1)	5,257	—	(28)	5,229
Corporate debt securities	292,392	6	(349)	292,049
Certificates of deposit	20,650	—	—	20,650
Total investments at December 31, 2018	$ 386,169	$ 23	$ (449)	$ 385,743

(1) Includes investments in notes issued by the Federal Home Loan Bank, Federal National Mortgage Association and Federal Farm Credit Banks.

Table of Contents

The maturity dates of the Company's investments as of December 31, 2018 are summarized below (in thousands):

	Amortized Cost	Estimated Fair Value
2019	$ 383,022	$ 382,582
2020	3,147	3,161
Total investments at December 31, 2018	$ 386,169	$ 385,743

Concentration of Credit Risk

Accounts receivable subjects the Company to a concentration of credit risk with third party payors that include health insurance companies, managed healthcare organizations, healthcare providers and governmental entities.

The Company maintains cash and cash equivalents balances at financial institutions which are insured by the Federal Deposit Insurance Corporation ("FDIC"). At times, balances in certain bank accounts may exceed the FDIC insured limits.

Pharmaceutical Inventory

Pharmaceutical inventory consists solely of finished goods (primarily prescription drugs) and is stated at the lower of first in first out, cost, or market.

Long lived Assets

Long lived assets, including property and equipment and intangible assets to be held and used, are currently reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. We group and evaluate these long-lived assets for impairment at the lowest level at which individual cash flows can be identified. Impairment is determined by comparing the carrying value of these long lived assets to management's best estimate of the future undiscounted cash flows expected to result from the use of the assets and their eventual disposition. The cash flow projections used to make this assessment are consistent with the cash flow projections that management uses internally in making key decisions. In the event an impairment exists, a loss is recognized based on the amount by which the carrying value exceeds the fair value of the asset, which is generally determined by using quoted market prices or the discounted present value of expected future cash flows.

In the evaluation of indefinite-lived intangible assets for impairment, the Company first assesses qualitative factors to determine whether it is more likely than not that the fair value of the indefinite-lived intangible asset is less than its carrying value. If the Company determines that it is not more likely than not for the indefinite-lived intangible asset's fair value to be less than its carrying value, a calculation of the fair value is not performed. If the Company determines that it is more likely than not that the indefinite-lived intangible asset's fair value is less than its carrying value, a calculation is performed and compared to the carrying value of the asset. If the carrying amount of the indefinite-lived intangible asset exceeds its fair value, an impairment loss is recognized in an amount equal to that excess. The Company measures the fair value of its indefinite-lived intangible assets using the "relief from royalty" method. Significant estimates in this approach include projected revenues and royalty and discount rates for each trade name evaluated.

Property and Equipment

Property and equipment is stated at cost, except for assets that have been impaired, for which the carrying amount has been reduced to estimated fair value. Expenditures for renewals and improvements are capitalized to the property accounts. Replacements and maintenance and repairs that do not improve or extend the life of the respective assets are expensed as incurred. The Company capitalizes costs incurred to develop internal use software during the application development stage. Capitalization of software development costs occurs after the preliminary project stage is complete, management authorizes the project, and it is probable that the project will be completed and the software will be used for the function intended. Amortization of capital lease assets is included in depreciation expense and is included in accumulated depreciation as reflected in the table below. Depreciation is provided on a straight line basis over the

Table of Contents

estimated useful lives of the assets, which is generally two to ten years for building improvements (or the lease term, if shorter), three to fifteen years for equipment and three to five years for capitalized internal use software. The net capitalized internal use software as of December 31, 2017 and 2018 was $79.6 million and $71.7 million, respectively. Depreciation expense was $75.3 million, $76.5 million and $80.9 million for the years ended December 31, 2016, 2017 and 2018, respectively. Included in depreciation expense for the years ended December 31, 2016, 2017 and 2018 was $47.6 million, $49.5 million and $50.0 million, respectively, related to capitalized internal-use software.

Property and equipment, net, consisted of the following at December 31, 2017 and 2018 (in thousands):

	2017	2018
Building improvements	$ 17,974	$ 18,954
Equipment	204,632	201,343
Capital leases - property	26,945	26,945
Capital leases - equipment	18,183	24,932
Capitalized internal-use software	486,013	527,129
	753,747	799,303
Accumulated depreciation	(595,109)	(648,555)
Property and equipment, net	$ 158,638	$ 150,748

Goodwill

The Company is required to test its goodwill for impairment on at least an annual basis. The Company has selected October 1 as the date of its annual impairment test. The goodwill impairment test is a two step process that requires management to make judgments in determining what assumptions to use in the calculation. The first step of the process consists of estimating the fair value of each reporting unit with goodwill based on various valuation techniques, with the primary technique being a discounted cash flow analysis, which requires the input of various assumptions with respect to revenues, operating margins, growth rates and discount rates. The estimated fair value for each reporting unit is compared to the carrying value of the reporting unit, which includes goodwill. If the estimated fair value is less than the carrying value, a second step is performed to compute the amount of the impairment by determining an “implied fair value” of goodwill. The determination of a reporting unit’s “implied fair value” of goodwill requires the Company to allocate the estimated fair value of the reporting unit to the assets and liabilities of the reporting unit. Any unallocated fair value represents the “implied fair value” of goodwill, which is compared to its corresponding carrying value.

Goodwill is tested for impairment at a level referred to as a reporting unit. The Company’s reporting units with goodwill as of December 31, 2017 were comprised of Commercial, Government and Pharmacy Management. During the third quarter of 2018, the Company re-evaluated how it was managing the Healthcare business segment and decided a reorganization was necessary to effectively manage the business going forward. As a result of this business reorganization, the Company concluded that changes to Healthcare’s reporting units were warranted. Healthcare now consists of two reporting units – Behavioral & Specialty Health and MCC. Effective August 1, 2018, the Company evaluated the impact of the reorganization on its previously identified reporting units. The Company allocated goodwill to the new reporting units using a relative fair value approach. In addition, the Company completed an assessment of any potential goodwill impairment for all reporting units immediately prior to and immediately after the reallocation and determined that no impairment existed.

The fair values of the Behavioral & Specialty Health (a component of the Healthcare segment), MCC (a component of the Healthcare segment) and Pharmacy Management reporting units were determined using a discounted cash flow method. This method involves estimating the present value of estimated future cash flows utilizing a risk adjusted discount rate. Key assumptions for this method include cash flow projections, terminal growth rates and discount

rates.

The 2018 annual goodwill impairment testing as of October 1,2018, determined that the fair value of the MCC reporting unit had declined, largely due to continued economic challenges in certain markets, and was in excess of its carrying value by a margin of approximately 5%. We considered our observed fourth quarter performance in our October 1, 2018 test. At December 31, 2018, we evaluated whether our forecast for 2019 and beyond would have changed from what was used in our October 1 test. Based on this evaluation, we continue to believe that the fair value of the MCC reporting unit exceeds its carrying value by a margin of approximately 5%. While the reporting unit was not determined to be impaired at this time, the MCC reporting unit goodwill is at risk of future impairment in the event of significant

Table of Contents

unfavorable changes in the Company's forecasted future results and cash flows. In addition, market factors utilized in the impairment analysis, including long-term growth rates or discount rates, could negatively impact the fair value of our reporting units. For testing purposes, management's best estimates of the expected future results are the primary driver in determining the fair value. Fair value determinations require considerable judgment and are sensitive to changes in underlying assumptions and factors. As a result, there can be no assurance that the estimates and assumptions made for purposes of the annual goodwill test will prove to be an accurate prediction of the future.

Examples of events or circumstances that could reasonably be expected to negatively affect the underlying key assumptions and ultimately impact the estimated fair value of our reporting units may include such items as: (i) a decrease in expected future cash flows, specifically, a decrease in membership or rates or customer attrition and increase in costs that could significantly impact our immediate and long-range results, unfavorable working capital changes and an inability to successfully achieve our cost savings targets, (ii) adverse changes in macroeconomic conditions or an economic recovery that significantly differs from our assumptions in timing and/or degree (such as a recession); and (iii) volatility in the equity and debt markets or other country specific factors which could result in a higher weighted-average cost of capital.

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

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

Goodwill for each of the Company's reporting units with goodwill at December 31, 2017 was as follows (in thousands):

	2017
Commercial	$ 242,255
Government	368,612
Pharmacy Management	395,421
Total	$ 1,006,288

Goodwill for each of the Company's reporting units with goodwill at December 31, 2018 was as follows (in thousands):

	2018
Behavioral & Specialty Health	$ 410,869
Magellan Complete Care	211,735
Pharmacy Management	395,552
Total	$ 1,018,156

Table of Contents

The changes in the carrying amount of goodwill for the years ended December 31, 2017 and 2018 are reflected in the table below (in thousands):

	2017	2018
Balance as of beginning of period	$ 742,054	$ 1,006,288
Acquisition of Veridicus	1,647	—
Acquisition of SWH	260,139	—
Other acquisitions and measurement period adjustments	2,448	11,868
Balance as of end of period	$ 1,006,288	$ 1,018,156

Intangible Assets

The Company reviews other intangible assets for impairment when events or changes in circumstances occur which may potentially impact the estimated useful life of the intangible assets. During the second quarter of 2016, the Company recognized $4.8 million in impairment charges, which are reflected in direct service costs and other operating expenses in the consolidated statements of income and reported within the Healthcare segment. The fair value of the impairment was determined using the income method, which resulted in the full impairment of the customer agreement intangible asset recorded in conjunction with the AlphaCare acquisition.

The following is a summary of intangible assets at December 31, 2017 and 2018, and the estimated useful lives for such assets (in thousands, except useful lives):

	December 31, 2017					
Asset	Original Useful Life		Weighted Avg Remaining Useful Life	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
Customer agreements and lists	2.5 to 18	years	5.3 years	$ 441,346	$ (218,335)	$ 223,011
Provider networks and other	1 to 16	years	3.0 years	25,410	(14,433)	10,977
Trade names and licenses	indefinite		indefinite	34,300	—	34,300
				$ 501,056	$ (232,768)	$ 268,288

	December 31, 2018					
Asset	Original Useful Life		Weighted Avg Remaining Useful Life	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
Customer agreements and lists	2.5 to 18	years	4.5 years	$ 441,346	$ (262,729)	$ 178,617
Provider networks and other	1 to 16	years	2.3 years	44,635	(21,789)	22,846
Trade names and licenses	indefinite		indefinite	30,420	—	30,420
				$ 516,401	$ (284,518)	$ 231,883

Amortization expense was $30.7 million, $39.2 million and $51.8 million for the years ended December 31, 2016, 2017 and 2018, respectively. The Company estimates amortization expense will be $54.7 million, $53.2 million, $46.9 million, $25.2 million and $17.2 million for the years ending December 31, 2019, 2020, 2021, 2022 and 2023, respectively.

Cost of Care, Medical Claims Payable and Other Medical Liabilities

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

The IBNR portion of medical claims payable is estimated based on past claims payment experience for member groups, enrollment data, utilization statistics, authorized healthcare services and other factors. This data is incorporated

Table of Contents

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

Medical claims payable balances are continually monitored and reviewed. If it is determined that the Company’s assumptions in estimating such liabilities are significantly different than actual results, the Company’s results of operations and financial position could be impacted in future periods. Adjustments of prior period estimates may result in additional cost of care or a reduction of cost of care in the period an adjustment is made. Further, due to the considerable variability of healthcare costs, adjustments to claim liabilities occur each period and are sometimes significant as compared to the net income recorded in that period. Prior period development is recognized immediately upon the actuary’s judgment that a portion of the prior period liability is no longer needed or that additional liability should have been accrued. The following table presents the components of the change in medical claims payable for the years ended December 31, 2016, 2017 and 2018 (in thousands):

	2016	2017	2018
Claims payable and IBNR, beginning of period	$ 253,299	$ 188,618	$ 326,642
Cost of care:			
Current year	1,892,914	2,421,270	3,772,112
Prior years(3)	(10,300)	(7,500)	(9,700)
Total cost of care	1,882,614	2,413,770	3,762,412
Claim payments and transfers to other medical liabilities(1):			
Current year	1,733,310	2,210,346	3,402,010
Prior years	213,985	161,798	292,904
Total claim payments and transfers to other medical liabilities	1,947,295	2,372,144	3,694,914
Acquisition of SWH	—	96,398	—
Claims payable and IBNR, end of period	188,618	326,642	394,140
Withhold (receivables) payable, end of period(2)	(4,482)	983	(593)
Medical claims payable, end of period	$ 184,136	$ 327,625	$ 393,547

(1) For any given period, a portion of unpaid medical claims payable could be covered by reinvestment liability (discussed below) and may not impact the Company’s results of operations for such periods.
(2) Medical claims payable is offset by customer withholds from capitation payments in situations in which the customer has the contractual requirement to pay providers for care incurred.
(3) Favorable development in 2016, 2017 and 2018 was $10.3 million, $7.5 million and $9.7 million, respectively, and was mainly related to lower medical trends and faster claims completion than originally assumed.

Actuarial standards of practice require that claim liabilities be adequate under moderately adverse circumstances. Adverse circumstances are situations in which the actual claims experience could be higher than the otherwise

estimated value of such claims. In many situations, the claims paid amount experienced will be less than the estimate that satisfies the actuarial standards of practice. Any prior period favorable cost of care development related to a lack of moderately adverse conditions is excluded from “Cost of Care – Prior Years” adjustments, as a similar provision for moderately adverse conditions is established for current year cost of care liabilities and therefore does not generally impact net income.

Due to the existence of risk sharing and reinvestment provisions in certain customer contracts, principally in the Government contracts, a change in the estimate for medical claims payable does not necessarily result in an equivalent impact on cost of care.

The Company believes that the amount of medical claims payable is adequate to cover its ultimate liability for unpaid claims as of December 31, 2018; however, actual claims payments may differ from established estimates.

Other medical liabilities consist primarily of amounts payable to pharmacies for claims that have been adjudicated by the Company but not yet paid and “profit share” payables under certain risk-based contracts. Under a contract with profit share provisions, if the cost of care is below certain specified levels, the Company will “share” the cost savings with the customer at the percentages set forth in the contract. In addition, certain contracts include provisions to provide the Company additional funding if the cost of care is above the specified levels. Other medical liabilities also include “reinvestment” payables under certain managed healthcare contracts with Medicaid customers. Under a contract with reinvestment features, if the cost of care is less than certain minimum amounts specified in the contract (usually as a percentage of revenue), the Company is required to “reinvest” such difference in behavioral healthcare programs when and as specified by the customer or to pay the difference to the customer for their use in funding such programs.

Accrued Liabilities

As of December 31, 2017, the only individual current liability that exceeded five percent of total current liabilities related to accrued employee compensation liabilities of $45.6 million. As of December 31, 2018, the only individual current liability that exceeded five percent of total current liabilities related to accrued customer settlement liabilities of $93.8 million.

Net Income per Common Share attributable to Magellan

Net income per common share attributable to Magellan is computed based on the weighted average number of shares of common stock and common stock equivalents outstanding during the period (see Note 6—“Stockholders’ Equity”).

Stock Compensation

At December 31, 2017 and 2018, the Company had equity-based employee incentive plans, which are described more fully in Note 6—“Stockholders’ Equity”. In addition, the Company issued restricted stock awards (“RSAs”) associated with the Armed Forces Services Corporation (“AFSC”) acquisition, which are also described more fully in Note 6—“Stockholders’ Equity”. The Company uses the Black Scholes Merton formula to estimate the fair value of substantially all stock options granted to employees, and recorded stock compensation expense of $37.4 million, $39.1 million and $29.5 million for the years ended December 31, 2016, 2017 and 2018, respectively. As stock compensation expense recognized in the consolidated statements of income for the years ended December 31, 2016, 2017 and 2018 is based on awards ultimately expected to vest, it has been reduced for annual estimated forfeitures of zero to four percent. If the actual number of forfeitures differs from those estimated, additional adjustments to compensation expense may be required in future periods. If vesting of an award is conditioned upon the achievement of performance goals, compensation expense during the performance period is estimated using the most probable outcome of the performance goals, and adjusted as the expected outcome changes. The Company recognizes compensation costs for awards that do not contain performance conditions on a straight line basis over the requisite service period, which is generally the vesting term of three years. For restricted stock units (“RSUs”) that include performance conditions, stock compensation is recognized using an accelerated method over the vesting period.

3. Acquisitions

Acquisition of SWH Holdings, Inc.

Pursuant to the July 13, 2017 Agreement and Plan of Merger ("the SWH Agreement"), on October 31, 2017 the Company acquired (the "SWH Acquisition") all of the outstanding equity interests of SWH Holdings, Inc. ("SWH"). SWH is a healthcare company focused on serving complex, high-risk populations, providing Medicare and Medicaid dual-eligible benefits to members in Massachusetts and New York.

Table of Contents

As consideration for the Acquisition, the Company paid $400.4 million, including a net payment of $0.4 million for working capital adjustments and a payment of $10.0 million based on SWH's Medicare plan in Massachusetts receiving a Centers for Medicare & Medicaid Services 2018 Star Rating of at least 4. The Company reports the results of operations of SWH in its Healthcare segment.

Acquisition of Veridicus Holdings, LLC and Granite Alliance Insurance Company

Pursuant to the November 19, 2016 purchase agreements (the "Veridicus Agreements") with Veridicus Holdings, LLC and Granite Alliance Insurance Company (collectively "Veridicus") and Veridicus Health, LLC, on December 13, 2016 and February 7, 2017 the Company acquired all of the outstanding equity interests of Veridicus (the "Veridicus Acquisition"). Veridicus is a PBM with a unique set of clinical services and capabilities.

As consideration for the Veridicus Acquisition, the Company paid $74.2 million, including net receipts of $0.3 million for working capital adjustments. The Company reports the results of operations of Veridicus within its Pharmacy Management segment.

Acquisition of AFSC

Pursuant to the May 15, 2016 share purchase agreement (the "AFSC Agreement") with AFSC, on July 1, 2016 the Company acquired all of the outstanding equity interests of AFSC (the "AFSC Acquisition"). AFSC has extensive experience providing and managing behavioral health and specialty services to various agencies of the federal government, including all five branches of the U.S. Armed Forces.

As consideration for the AFSC Acquisition, the Company paid $114.5 million, including net receipts of $3.0 million for working capital adjustments. In addition to the base purchase price, the AFSC Agreement provides for potential contingent payments up to a maximum aggregate amount of $10.0 million. The potential contingent payments are based on the retention of certain core business by AFSC. The Company reports the results of operations of AFSC within its Healthcare segment.

Other Acquisition

Pursuant to the February 9, 2016 purchase agreement (the "TMG Agreement") with The Management Group, LLC ("TMG"), on February 29, 2016 the Company acquired all of the outstanding equity interests of TMG. TMG is a company with 30 years of expertise in community-based long-term care services and supports. As consideration for the transaction, the Company paid a base price of $14.8 million in cash, including net receipts of $0.2 million for working capital adjustments. In addition to the base purchase price, the TMG agreement provides for potential contingent payments up to a maximum aggregate of $15.0 million. The potential future payments are contingent upon the Company being awarded additional managed long-term services and supports contracts. The Company reports the results of operations of TMG within its Healthcare segment.

4. Benefit Plans

The Company has a defined contribution retirement plan (the "401(k) Plan"). Employee participants can elect to contribute up to 75 percent of their compensation, subject to Internal Revenue Service ("IRS") deferral limitations. The Company makes contributions to the 401(k) Plan based on employee compensation and contributions. The Company

matches 50 percent of each employee's contribution up to 6 percent of their annual compensation. The Company recognized $11.1 million, $12.7 million and $14.9 million of expense for the years ended December 31, 2016, 2017 and 2018, respectively, for matching contributions to the 401(k) Plan.

5. Long Term Debt, Capital Lease and Deferred Financing Obligations

Senior Notes

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

Indenture" together, with the Base Indenture, the "Indenture"), between the Company, as issuer, and U.S. Bank National Association, as trustee.

The Notes bear interest payable semiannually in cash in arrears on March 22 and September 22 of each year, commencing on March 22, 2018, which rate is subject to an interest rate adjustment upon the occurrence of certain credit rating events. The Notes mature on September 22, 2024. The Indenture provides that the Notes are redeemable at the Company's option, in whole or in part, at any time on or after July 22, 2024, at a redemption price equal to 100% of the principal amount of the Notes being redeemed plus accrued and unpaid interest thereon to, but excluding, the redemption date.

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

The net proceeds from the issuance and sale of the Notes were approximately $394.7 million after deducting the underwriting discounts and commissions and offering expenses. The net proceeds from this offering were and will be used for working capital and general corporate purposes, and the termination and repayment of the obligations under its Previous Credit Agreements (as defined below) which were scheduled to expire on July 23, 2019 and December 29, 2017.

Terminated Credit Agreements

On July 23, 2014, the Company entered into a $500.0 million Credit Agreement with various lenders that provided for Magellan Rx Management, Inc. (a wholly owned subsidiary of Magellan) to borrow up to $250.0 million of revolving loans, with a sublimit of up to $70.0 million for the issuance of letters of credit for the account of the Company, and a term loan in an original aggregate principal amount of $250.0 million (the "2014 Credit Facility"). On December 2, 2015, the Company entered into an amendment to the 2014 Credit Facility under which Magellan Pharmacy Services, Inc. (a wholly owned subsidiary of Magellan) became a party to the $500.0 million Credit Agreement as the borrower and assumed all of the obligations of Magellan Rx Management, Inc. Under the 2014 Credit Facility, on September 30, 2014, the Company completed a draw-down of the $250.0 million term loan (the "2014 Term Loan"). The 2014 Credit Facility was scheduled to mature on July 23, 2019. Upon consummation of the Refinancing (as defined below) on September 22, 2017, the 2014 Credit Facility was terminated.

On June 27, 2016, the Company entered into a $200.0 million Credit Agreement with various lenders that provided for a $200.0 million term loan (the "2016 Term Loan") to Magellan Pharmacy Services, Inc. (the "2016 Credit Facility"). The 2016 Credit Facility was scheduled to mature on December 29, 2017. Upon consummation of the Refinancing (as defined below) on September 22, 2017, the 2016 Credit Facility was terminated.

On January 10, 2017, the Company entered into a Credit Agreement with various lenders that provided for a $200.0 million delayed draw term loan (the "2017 Term Loan") to Magellan Pharmacy Services, Inc. (the "2017 Credit Facility"). The 2017 Credit Facility was scheduled to mature on December 29, 2017. Upon consummation of the Refinancing (as defined below) on September 22, 2017, the 2017 Credit Facility was terminated.

Active Credit Agreements

On September 22, 2017, the Company entered into a credit agreement with various lenders that provides for a $400.0 million senior unsecured revolving credit facility and a $350.0 million senior unsecured term loan facility to the Company, as the borrower (the "2017 Credit Agreement"). On August 13, 2018, the Company entered into an amendment to the 2017 Credit Agreement, which extended the maturity date by one year. On February 27, 2019, the

Company entered into a second amendment to the 2017 Credit Agreement, which amended the total leverage ratio covenant, and which was necessary in order for us to remain in compliance with the terms of the 2017 Credit Agreement. The 2017 Credit Agreement is scheduled to mature on September 22, 2023.

The proceeds from the 2017 Credit Agreement were and will be used for (a) working capital and general corporate purposes of the Company and its subsidiaries, including investments and the funding of acquisitions, (b) the repayment of all outstanding loans and other obligations (and the termination of all commitments) under the 2014 Credit Facility, 2016 Credit Facility and 2017 Credit Facility (collectively, the “Previous Credit Agreements”) (the termination

and repayment of the obligations under the Previous Credit Agreements, collectively, the "Refinancing") and (c) payment of fees and expenses incurred in connection with (i) the entering into the 2017 Credit Agreement and related documents and the incurrence of loans and issuance of letters of credit thereunder and (ii) the consummation of the Refinancing. Upon consummation of the Refinancing, the Previous Credit Agreements were terminated.

Under the 2017 Credit Agreement, the annual interest rate on the loan borrowing is equal to (i) in the case of base rate loans, the sum of an initial borrowing margin of 0.500 percent plus the higher of the prime rate, one-half of one percent in excess of the overnight "federal funds" rate, or the Eurodollar rate for one month plus 1.000 percent, or (ii) in the case of Eurodollar rate loans, the sum of an initial borrowing margin of 1.500 percent plus the Eurodollar rate for the selected interest period. The borrowing margin is subject to adjustment based on the Company's debt rating as provided by certain rating agencies. The Company has the option to borrow in base rate loans or Eurodollar rate loans at its discretion. The commitment commission on the revolving credit facility under the 2017 Credit Agreement is 0.200 percent of the unused revolving credit commitment, which rate shall be subject to adjustment based on the Company's debt rating as provided by certain rating agencies. For the year ended December 31, 2018, the weighted average interest rate was approximately 3.62 percent.

As of December 31, 2018, the contractual maturities of the term loan under the 2017 Credit Agreement were as follows: 2019—$17.5 million; 2020—$17.5 million; 2021—$17.5 million; 2022—$17.5 million; and 2023—$258.1 million. A December 31, 2017, the Company had revolving loan borrowings of $92.5 million. At December 31, 2018, the Company had no revolving loan borrowings, resulting in a borrowing capacity of $400.0 million under the 2017 Credit Agreement. Included in long-term debt and capital lease and deferred financing obligations as of December 31, 2017 and December 31, 2018 are deferred loan issuance costs of $6.6 million and $5.9 million, respectively.

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

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

Letter of Credit Agreement

On August 22, 2017, the Company entered into a Continuing Agreement for Standby Letters of Credit with The Bank of Tokyo-Mitsubishi UFJ, Ltd. ("BTMU"), as issuer (the "L/C Agreement"), under which BTMU, at its sole discretion, may provide stand-by letter of credit to the Company. The Company had $26.5 million and $66.1 million of letters of credit outstanding under the L/C Agreement at December 31, 2017 and 2018, respectively.

Capital Lease and Deferred Financing Obligations

There were $22.9 million and $31.2 million of capital lease and deferred financing obligations at December 31, 2017 and December 31, 2018, respectively. The Company's capital lease and deferred financing

Table of Contents

obligations represent amounts due under leases for certain properties, computer software (acquired prior to the prospective adoption of ASU 2015-05 on January 1, 2016) and equipment. The recorded gross cost of capital leased assets was $45.1 million and $51.9 million at December 31, 2017 and 2018, respectively.

6. Stockholders' Equity

Stock Compensation

At December 31, 2017 and 2018, the Company had equity-based employee incentive plans. Prior to May 18, 2016, the Company utilized the 2011 Management Incentive Plan (the "2011 MIP"), 2008 Management Incentive Plan (the "2008 MIP") and 2006 Directors' Equity Compensation Plan (collectively the "Preexisting Plans") for grants of stock options, RSAs, RSUs, and stock appreciation rights, to provide incentives to officers, employees and non-employee directors.

On February 25, 2016, the board of directors of the Company approved the 2016 Management Incentive Plan ("2016 MIP"), and the 2016 MIP was approved by the Company's shareholders at the 2016 Annual Meeting of Shareholders on May 18, 2016. The 2016 MIP provides for the delivery of up to a number of shares equal to (i) 4,000,000 shares of common stock, plus (ii) the number of shares subject to outstanding awards under the 2011 MIP and Preexisting Plans which become available after shareholder approval of the 2016 MIP as a result of forfeitures, expirations, and in other permitted ways under the share recapture provisions of the 2016 MIP. Delivery of shares under "full-value" awards (awards other than options or stock appreciation rights) will be counted for each share delivered as 1.60 shares against the total number of shares reserved under the 2016 MIP.

The 2016 MIP provides for awards of stock options, RSAs, RSUs, performance-based restricted stock units ("PSUs"), stock appreciation rights, cash denominated awards and any combination of the foregoing. A RSU is a notional account representing the right to receive a share of the Company's Common Stock (or, at the Company's option, cash in lieu thereof) at some future date. In general, stock options vest ratably on each anniversary over the three years subsequent to grant, and have a ten year life. With the exception of the shares received by the principal owners of Partners Rx, CDMI and AFSC, RSAs generally vest on the anniversary of the grant. In general, RSUs vest ratably on each anniversary over the three years subsequent to grant. The PSUs vest over three years and are subject to market-based conditions. At December 31, 2018, 3,282,964 shares of the Company's common stock remain available for future grant under the Company's 2016 MIP.

On February 27, 2014 the board of directors of the Company approved the 2014 Employee Stock Purchase Plan ("2014 ESPP"), and the 2014 ESPP was approved by the Company's shareholders at the 2014 Annual Meeting of Shareholders on May 21, 2014. The 2014 ESPP provides for up to 200,000 shares of the Company's common stock, plus the number of shares remaining under the 2011 Employee Stock Purchase Plan, to be issued. On May 24, 2018, the Company's shareholders approved an amendment to the 2014 ESPP to increase by 300,000 the number of shares available for issuance under the plan. During the years ended December 31, 2017 and 2018, 56,426 and 63,471 shares of the Company's common stock were issued under the employee stock purchase plans, respectively. At December 31, 2018, 308,716 shares of the Company's common stock remain available for future grant under the Company's 2014 ESPP.

Table of Contents

Stock Options

Summarized information related to the Company’s stock options for the years ended December 31, 2016, 2017 and 2018 is as follows:

	2016		2017	
	Options	Weighted Average Exercise Price	Options	Weighted Average Exercise Price
Outstanding, beginning of period	2,939,840	$ 55.13	2,843,177	$ 57.42
Granted	501,960	64.10	525,596	71.35
Forfeited	(104,680)	57.23	(79,350)	61.39
Exercised	(493,943)	50.60	(831,186)	53.79
Outstanding, end of period	2,843,177	57.42	2,458,237	61.50

	2018			
	Options	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (in years)	Aggregate Intrinsic Value (in thousands)
Outstanding, beginning of period	2,458,237	$ 61.50		
Granted	477,956	96.39		
Forfeited	(174,376)	80.21		
Exercised	(409,208)	56.36		
Outstanding, end of period	2,352,609	$ 68.10	5.78	$ 2,551
Vested and expected to vest at end of period	2,342,100	$ 68.02	5.77	$ 2,551
Exercisable, end of period	1,552,236	$ 60.40	4.31	$ 2,539

The aggregate intrinsic value in the table above represents the total pre tax intrinsic value (based upon the difference between the Company’s closing stock price on the last trading day of 2018 of $56.89 and the exercise price) for all in the money options as of December 31, 2018. This amount changes based on the fair market value of the Company’s common stock.

The total pre tax intrinsic value of options exercised during the years ended December 31, 2016, 2017 and 2018 was $9.3 million, $23.8 million, and $17.3 million, respectively.

The weighted average grant date fair value per share of substantially all stock options granted during the years ended December 31, 2016, 2017 and 2018 was $15.05, $17.64 and $25.34, respectively, as estimated using the Black Scholes Merton option pricing model based on the following weighted average assumptions:

	2016		2017		2018	
Risk-free interest rate	1.16	%	1.79	%	2.54	%
Expected life	4	years	4	years	4	years
Expected volatility	27.75	%	27.75	%	28.20	%
Expected dividend yield	0.00	%	0.00	%	0.00	%

For the years ended December 31, 2016, 2017 and 2018, expected volatility was based on the historical volatility of the Company’s stock price.

As of December 31, 2018, there was $7.8 million of total unrecognized compensation expense related to nonvested stock options that is expected to be recognized over a weighted average remaining recognition period of 1.94 years. The total fair value of options vested during the year ended December 31, 2018 was $8.6 million.

Table of Contents

In the year ended December 31, 2016, the net tax benefit from excess tax deductions was $0.8 million, which consists of $1.0 million of excess tax benefits offset by $0.2 million of tax deficiencies. In the year ended December 31, 2017, the net tax benefit from excess tax deductions was $5.6 million, which consists of $5.7 million of excess tax benefits offset by $0.1 million of tax deficiencies. In the year ended December 31, 2018, the net tax benefit from excess tax deductions was $5.1 million; tax deficiencies were insignificant.

Restricted Stock Awards

Summarized information related to the Company's nonvested RSAs for the years ended December 31, 2016, 2017 and 2018 is as follows:

	2016		2017		2018	
	Shares	Weighted Average Grant Date Fair Value	Shares	Weighted Average Grant Date Fair Value	Shares	Weighted Average Grant Date Fair Value
Outstanding, beginning of period	1,109,622	$ 57.88	615,472	$ 58.71	31,102	$ 68.00
Awarded	77,744	65.52	14,959	70.20	11,795	89.05
Vested	(571,894)	58.03	(585,438)	58.33	(31,102)	68.00
Forfeited	—	—	(13,891)	65.97	—	—
Outstanding, ending of period	615,472	58.71	31,102	68.00	11,795	89.05

(1) December 31, 2016 includes 60,069 shares associated with the AFSC acquisition.
As of December 31, 2018, there was $0.4 million of unrecognized stock compensation expense related to nonvested restricted stock awards. This cost is expected to be recognized over a weighted average period of 0.39 years.

Restricted Stock Units

Summarized information related to the Company's nonvested RSUs for the years ended December 31, 2016, 2017 and 2018 is as follows:

	2016		2017		2018	
	Shares	Weighted Average Grant Date Fair Value	Shares	Weighted Average Grant Date Fair Value	Shares	Weighted Average Grant Date Fair Value
Outstanding, beginning of period	231,088	$ 61.53	200,178	$ 61.65	163,289	$ 66.46
Awarded	51,521	64.87	107,417	68.53	111,033	99.29
Vested	(53,839)	63.32	(119,489)	60.38	(84,627)	65.20
Forfeited	(28,592)	63.34	(24,817)	65.87	(32,945)	84.17
Outstanding, ending of period	200,178	61.65	163,289	66.46	156,750	86.68

As of December 31, 2018, there was $8.5 million of unrecognized stock compensation expense related to nonvested restricted stock units. This cost is expected to be recognized over a weighted-average period of 1.89 years.

Table of Contents

Performance-Based Restricted Stock Units

Summarized information related to the Company's nonvested PSUs for the years ended December 31, 2016, 2017 and 2018 is as follows:

	2016		2017		2018	
	Shares	Weighted Average Grant Date Fair Value	Shares	Weighted Average Grant Date Fair Value	Shares	Weighted Average Grant Date Fair Value
Outstanding, beginning of period	36,938	$ 85.00	102,977	$ 93.03	202,315	$ 84.63
Awarded	69,691	97.22	101,989	76.24	80,502	141.61
Vested	—	—	—	—	(33,592)	85.00
Forfeited	(3,652)	91.89	(2,651)	87.75	(40,206)	100.96
Outstanding, end of period	102,977	93.03	202,315	84.63	209,019	103.38

The PSUs will entitle the grantee to receive a number of shares of the Company's Common Stock determined over a three-year performance period ending on December 31 of the year prior to the settlement date of the awards, provided the grantee remains in the service of the Company on the settlement date. The Company expenses the cost of PSU awards ratably over the requisite service period. The number of shares for which the PSUs will be settled will be a percentage of shares for which the award is targeted and will depend on the Company's total shareholder return (as defined below), expressed as a percentile ranking of the Company's total shareholder return as compared to the Company's peer group (as defined below). The number of shares for which the PSUs will be settled vary from zero to 200 percent of the shares specified in the grant. Total shareholder return is determined by dividing the average share value of the Company's Common Stock over the 30 trading days preceding January 1 of the year the awards are scheduled to vest by the average share value of the Company's Common Stock over the 30 trading days beginning on January 1 of the year the awards were granted, with a deemed reinvestment of any dividends declared during the performance period. The Company's peer group includes companies which comprise the S&P Health Care Services Industry Index, which was selected by the Compensation Committee of the Company's Board of Directors and includes a range of healthcare companies operating in several business segments.

The weighted average estimated fair value of the PSUs granted in the year ended December 31, 2016 was $97.22, which was derived from a Monte Carlo simulation. Significant assumptions utilized in estimating the value of the awards granted include an expected dividend yield of 0%, a risk-free rate of 1%, and expected volatility of 16% to 81% (average of 32%).

The weighted average estimated fair value of the PSUs granted in the year ended December 31, 2017 was $76.24, which was derived from a Monte Carlo simulation. Significant assumptions utilized in estimating the value of the awards granted include an expected dividend yield of 0%, a risk-free rate of 1.54%, and expected volatility of 18% to 61% (average of 33%).

The weighted average estimated fair value of the PSUs granted in the year ended December 31, 2018 was $141.61, which was derived from a Monte Carlo simulation. Significant assumptions utilized in estimating the value of the awards granted include an expected dividend yield of 0%, a risk-free rate of 2.37%, and expected volatility of 20% to 82% (average of 35%).

As of December 31, 2018, there was $5.1 million of unrecognized stock compensation expense related to nonvested PSUs. This cost is expected to be recognized over a weighted average period of 1.78 years.

Table of Contents

Net Income per Common Share Attributable to Magellan

The following table reconciles income (numerator) and shares (denominator) used in the Company's computations of net income per share for the years ended December 31, 2016, 2017 and 2018 (in thousands, except per share data):

	2016	2017	2018
Numerator:			
Net income attributable to Magellan	$ 77,879	$ 110,207	$ 24,181
Denominator:			
Weighted average number of common shares outstanding—basic	23,181	23,333	24,349
Common stock equivalents—stock options	289	530	493
Common stock equivalents—RSAs	593	376	15
Common stock equivalents—RSUs	45	64	37
Common stock equivalents—PSUs	45	134	137
Common stock equivalents—employee stock purchase plan	3	3	4
Weighted average number of common shares outstanding—diluted	24,156	24,440	25,035
Net income attributable to Magellan per common share—basic	$ 3.36	$ 4.72	$ 0.99
Net income attributable to Magellan per common share—diluted	$ 3.22	$ 4.51	$ 0.97

The weighted average number of common shares outstanding for the years ended December 31, 2016, 2017 and 2018 was calculated using outstanding shares of the Company's common stock. Common stock equivalents included in the calculation of diluted weighted average common shares outstanding for the years ended December 31, 2016, 2017 and 2018 represent stock options to purchase shares of the Company's common stock, restricted stock awards, restricted stock units and stock purchased under the ESPP.

For the years ended December 31, 2016, 2017 and 2018, the Company had additional potential dilutive securities outstanding representing 1.5 million, 0.4 million and 0.5 million options, respectively, that were not included in the computation of dilutive securities because they were anti dilutive for such periods. Had these shares not been anti dilutive, all of these shares would not have been included in the net income per common share calculation as the Company uses the treasury stock method of calculating diluted shares.

Stock Repurchases

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

On October 26, 2015, the Company's board of directors approved a stock repurchase plan which authorized the Company to purchase up to $200 million of its outstanding common stock through October 22, 2017. On July 26, 2017, the Company's board of directors approved an extension of the 2015 Repurchase Program through October 22, 2018. On May 24, 2018, the Company's board of directors approved an increase of $200 million to the current $200 million stock repurchase plan which now authorizes the Company to purchase up to $400 million of its outstanding common stock under the 2015 Repurchase Program. As of December 31, 2018, the remaining capacity under the 2015 Repurchase Program was $190.0 million. The board also extended the program from October 22, 2018 to October 22, 2020. Pursuant

Table of Contents

to this program, the Company made purchases as follows (aggregate cost excludes broker commissions and is reflected in millions):

Period	Total Number of Shares Purchased	Average Price Paid per Share	Aggregate Cost
October 26, 2015 - December 31, 2015	345,044	$ 53.46	$ 18.4
January 1, 2016 - December 31, 2016	1,828,183	58.40	106.8
January 1, 2017 - December 31, 2017	280,140	77.67	21.8
January 1, 2018 - December 31, 2018	844,872	74.59	63.0
	3,298,239		$ 210.0

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

Recent Sales of Unregistered Securities

On May 15, 2016, the Company and AFSC entered into a purchase agreement pursuant to which on July 1, 2016, the sellers and key management of AFSC purchased 60,069 shares of the Company's restricted stock for a total purchase price of $4.0 million. The aggregate number of shares issued was determined by dividing $4.0 million by the average trading prices per share of Magellan's common stock on the NASDAQ over the five trading days ended on the trading day prior to the execution of the purchase agreement. The shares received by such sellers and key management of AFSC are subject to vesting over two years with 50% vesting on the first anniversary of the acquisition and 50% vesting on the second anniversary of the acquisition, conditioned on continued employment with the Company on the applicable vesting dates. The shares were issued to the sellers and key management of AFSC in a private placement pursuant to Section 4(a)(2) of the Securities Act.

7. Income Taxes

Income Tax Expense

On December 22, 2017, the President of the United States signed into law the Tax Cuts and Jobs Act (the "Tax Act"). The legislation includes a number of changes to existing U.S. tax laws that impact the Company, most notably a reduction of the U.S. corporate income tax rate from 35 percent to 21 percent, effective January 1, 2018. The legislation also provides for the acceleration of depreciation on certain assets placed in service after September 27, 2017, as well as changes beginning in 2018, including additional limitations on the deduction of executive compensation.

The components of income tax expense (benefit) for the following years ended December 31 were as follows (in thousands):

	2016	2017	2018
Income taxes currently payable:			
Federal	$ 59,343	$ 49,944	$ 13,593
State	5,675	6,120	7,145
	65,018	56,064	20,738
Deferred income taxes (benefits):			

Federal	3,830	(31,941)	307
State	880	960	(2,032)
	4,710	(30,981)	(1,725)
Total income tax expense	$ 69,728	$ 25,083	$ 19,013

Table of Contents

Total income tax expense for the years ended December 31 was different from the amount computed using the statutory federal income tax rate in effect for each respective year for the following reasons (in thousands):

	2016	2017	2018
Income tax expense at federal statutory rate	$ 50,931	$ 47,328	$ 9,071
State income taxes, net of federal income tax benefit	5,799	4,993	2,968
State contingencies added	2,120	2,161	3,644
Tax contingencies reversed due to statute closings	(1,632)	(2,044)	(2,651)
Change in valuation allowances	2,130	(14,973)	(691)
Adjustments for Tax Act	—	(8,677)	335
Share-based compensation	(232)	(4,724)	(4,750)
Qualified research credit	(1,002)	(1,325)	(1,781)
Non-deductible executive compensation	34	104	3,052
Non-deductible HIF fees	10,204	—	8,246
Other-net	1,376	2,240	1,570
Total income tax expense	$ 69,728	$ 25,083	$ 19,013

On December 22, 2017, the SEC staff issued Staff Accounting Bulletin No. 118 (“SAB 118”) to address the application of U.S. GAAP in situations when a registrant did not have the necessary information available, prepared, or analyzed (including computations) in reasonable detail to complete the accounting for certain income tax effects of the Tax Act. SAB 118 allows registrants to determine a reasonable estimate to be included as provisional amounts and provides a measurement period by which the accounting must be completed.

Because the Company had not yet completed its accounting for the effects of the Tax Act at the time, provisional amounts were recorded in 2017 for the enactment-date effects by applying the guidance in SAB 118. As a result of the reduction in the U.S. corporate income tax rate from 35% to 21% under the Tax Act, the Company remeasured its ending net deferred tax liabilities at December 31, 2017 and recorded a provisional tax benefit of $8.2 million. The Company has now completed its accounting for all of the enactment-date income tax effects of the Tax Act. As a result, an adjustment of $0.3 million to the provisional amounts is included as a component of income tax expense for 2018.

Deferred Income Taxes

The significant components of deferred tax assets and liabilities at December 31 were as follows (in thousands):

	2017	2018
Deferred tax assets:		
Net operating loss carryforwards	$ 13,384	$ 11,159
Share-based compensation	9,639	10,299
Other accrued compensation	6,195	5,508
Claims reserves	4,527	7,053
Deferred revenue	2,606	4,368
Other non-deductible accrued liabilities	5,362	6,057
Indirect tax benefits	2,847	3,296
Other deferred tax assets	2,051	2,130
Total deferred tax assets	46,611	49,870
Valuation allowances	(2,368)	(1,521)
Deferred tax assets after valuation allowances	44,243	48,349
Deferred tax liabilities:		
Depreciation	(22,906)	(21,350)
Amortization of goodwill and intangible assets	(29,501)	(30,463)
Other deferred tax liabilities	(3,321)	(4,292)
Total deferred tax liabilities	(55,728)	(56,105)
Net deferred tax assets (liabilities)	$ (11,485)	$ (7,756)

The Company has $27.7 million of federal net operating loss carryforwards (“NOLs”) available to reduce consolidated taxable income in 2019 and subsequent years. These NOLs (including $27.1 million incurred by AlphaCare prior to its membership in the Magellan consolidated group) will expire in 2019 through 2035 if not used and are subject to examination and adjustment by the IRS. In addition, the Company’s utilization of these NOLs is subject to limitations under the Internal Revenue Code as to the timing and use. At this time, the Company does not believe these limitations will restrict the Company’s ability to use any federal NOLs before they expire. The Company and its subsidiaries also have $88.2 million of NOLs available to reduce state and local taxable income at certain subsidiaries in 2019 and subsequent years. These NOLs will expire in 2019 through 2038 if not used and are subject to examination and adjustment by the respective tax authorities. In addition, the Company’s utilization of certain of these NOLs is subject to limitations as to the timing and use. At this time, the Company does not believe these limitations will restrict the Company’s ability to use any of these state and local NOLs before they expire.

The Company’s valuation allowances against deferred tax assets were $2.4 million and $1.5 million as of December 31, 2017 and 2018, respectively. The change in valuation allowance of $0.9 million was reflected as a reduction to income tax expense. These allowances primarily relate to uncertainties regarding the eventual realization of certain state NOLs.

Reversals of valuation allowances are recorded in the period they occur, typically as reductions to income tax expense. Determination of the amount of deferred tax assets considered realizable requires significant judgment and estimation regarding the forecasts of future taxable income which are consistent with the plans and estimates the Company uses to manage the underlying businesses. Although consideration is also given to potential tax planning strategies which

might be available to improve the realization of deferred tax assets, none were identified which were both prudent and reasonable. The Company believes taxable income expected to be generated in the future will be sufficient to support realization of the Company's deferred tax assets, as reduced by valuation allowances. This determination is based upon earnings history and future earnings expectations.

Other than deferred tax benefits attributable to operating loss carryforwards, there are no time constraints within which the Company's deferred tax assets must be realized. Future changes in the estimated realizability of deferred tax assets could materially affect the Company's financial condition and results of operations.

Uncertain Tax Positions

A reconciliation of the beginning and ending amount of gross unrecognized tax benefits is as follows (in thousands):

	2016	2017	2018
Balance as of beginning of period	$ 12,597	$ 13,604	$ 13,580
Additions for current year tax positions	3,274	3,243	4,955
Additions for tax positions of prior years	141	342	512
Reductions for tax positions of prior years	(173)	(114)	(398)
Reductions due to lapses of applicable statutes of limitations	(2,235)	(2,693)	(3,005)
Changes due to Tax Act	—	(509)	339
Reductions due to settlements with taxing authorities	—	(293)	(300)
Balance as of end of period	$ 13,604	$ 13,580	$ 15,683

If these unrecognized tax benefits had been realized as of December 31, 2017 and 2018, $10.7 million and $12.3 million, respectively, would have reduced income tax expense.

The Company continually performs a comprehensive review of its tax positions and accrues amounts for tax contingencies related to uncertain tax positions. Based upon these reviews, the status of ongoing tax audits and the expiration of applicable statutes of limitations, accruals are adjusted as necessary. The tax benefit from an uncertain tax position is recognized when it is more likely than not that, based on the technical merits, the position will be sustained upon examination, including resolution of any related appeals or litigation processes.

The Company also adjusts these liabilities for unrecognized tax benefits when its judgment changes as a result of the evaluation of new information not previously available. However, the ultimate resolution of a disputed tax position following an examination by a taxing authority could result in a payment that is materially different from that accrued by the Company. These differences are typically reflected as increases or decreases to income tax expense in the period in which they are determined.

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

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

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

With few exceptions, the Company is no longer subject to income tax assessments by tax authorities for years ended prior to 2015. Further, it is reasonably possible the statutes of limitations regarding the assessment of federal and most state and local income taxes for 2015 could expire during 2019. Up to $3.6 million of unrecognized tax benefits recorded as of December 31, 2018 could be reversed during 2019 as a result of statute expirations, of which $2.9 million would be reflected as a reduction to income tax expense and $0.7 million as a decrease to deferred tax assets. All reversals from statute expirations would be reflected as discrete adjustments during the quarter in which the respective event occurs. As of December 31, 2017 and 2018, the Company had accrued approximately $0.5 million and $0.6

Table of Contents

million, respectively, for the potential payment of interest and penalties. The Company accrues interest and penalties related to unrecognized tax benefits in its provision for income taxes. During the years ended December 31, 2016, 2017 and 2018, the Company recorded approximately $0.1 million, $0.2 million and $0.1 million, respectively, in interest and penalties.

8. Supplemental Cash Flow Information

Supplemental cash flow information for the years ended December 31, 2016, 2017 and 2018 is as follows (in thousands):

	2016	2017	2018
Income taxes paid, net of refunds	$ 54,442	$ 59,474	$ 40,179
Interest paid	$ 9,378	$ 15,415	$ 34,223
Assets acquired through capital leases and deferred financing	$ 4,491	$ 2,418	$ 20,576

9. Commitments and Contingencies

Insurance

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

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

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

Regulatory Issues

The managed healthcare industry is subject to numerous laws and regulations. The subjects of such laws and regulations cover, but are not limited to, matters such as licensure, accreditation, government healthcare program participation requirements, information privacy and security, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Over the past several years, government activity has increased with respect to investigations and/or allegations concerning possible violations of fraud and abuse and false claims statutes and/or

regulations by healthcare organizations and insurers. Entities that are found to have violated these laws and regulations may be excluded from participating in government healthcare programs, subjected to fines or penalties or required to repay amounts received from the government for previously billed patient services. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

In addition, regulators of certain of the Company’s subsidiaries may exercise certain discretionary rights under regulations including increasing their supervision of such entities, requiring additional restricted cash or other security or seizing or otherwise taking control of the assets and operations of such subsidiaries.

The Company is subject to certain federal laws and regulations in connection with its contracts with the federal government. These laws and regulations affect how the Company conducts business with its federal agency customers

Table of Contents

and may impose added costs on its business. The Company's failure to comply with federal procurement laws and regulations could cause it to lose business, incur additional costs and subject it to a variety of civil and criminal penalties and administrative sanctions, including termination of contracts, forfeiture of profits, harm to reputation, suspension of payments, fines, and suspension or debarment from doing business with federal government agencies. The Company's wholly owned subsidiary, AFSC, conducts business with federal agency customers and federal contractors to such agencies. The Company is investigating, with the assistance of outside counsel, matters relating to compliance by AFSC with Small Business Administration ("SBA") regulations and other federal laws applicable to government contractors and has reported findings to the SBA and the Department of Defense, including facts indicating violations of SBA regulations and other federal laws, such as the Anti-Kickback Act, by former AFSC executives, none of which was disclosed to Magellan prior to its acquisition of AFSC. The Company is voluntarily responding to government requests for further information regarding the Company's investigation. Contingencies, if any, arising from the results of this investigation and self-reporting could require us to record balance sheet liabilities or accrue expenses, the amount of which we are not able to currently estimate. While the Company believes that it has responded appropriately by self-reporting findings regarding matters that incepted prior to its acquisition of AFSC in order to mitigate the risk of adverse consequences, should the SBA, Department of Defense and/or other federal agencies seek to hold the Company or AFSC responsible for the reported conduct, we may be required to pay damages and/or penalties and AFSC could be suspended or debarred from government contracting. For 2017 and 2018 AFSC's total revenue comprised approximately 3% and 2%, respectively, of the total revenues of the Company.

Legal

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

The Company is also subject to or party to certain class actions and other litigation and claims relating to its operations or business practices. The Company has recorded reserves that, in the opinion of management, are adequate to cover litigation, claims or assessments that have been or may be asserted against the Company, and for which the outcome is probable and reasonably estimable. Management believes that the resolution of such litigation and claims will not have a material adverse effect on the Company's financial condition or results of operations; however, there can be no assurance in this regard.

A Pharmacy Management segment network provider and the Company are currently in dispute regarding pricing and associated calculations pertaining to network reconciliations for a multi-year period. Depending upon the resolution of the dispute, the Company could incur liability to this provider. The unrecorded, potential loss related to these network reconciliations is estimated to range from $0 to $22 million. The ultimate resolution of this matter, if unfavorable, could be material to the Company's results of operations.

Operating Leases

The Company leases certain of its operating facilities and equipment. The leases, which expire at various dates through November 2025, generally require the Company to pay all maintenance, property tax and insurance costs.

At December 31, 2018, aggregate amounts of future minimum payments under operating leases were as follows: 2019—$20.9 million; 2020—$16.4 million; 2021—$14.1 million; 2022—$12.4 million; 2023—$8.0 million; 2024 and beyond—$10.4 million. Operating lease obligations include estimated future lease payments for both open and closed offices.

At December 31, 2018, aggregate amounts of future minimum rentals to be received under operating subleases were $0.4 million. All of the Company's operating subleases at December 31, 2018 are scheduled to terminate in 2019. Operating sublease rentals to be received mainly relate to a portion of the Company's former headquarters.

Table of Contents

Rent expense is recognized on a straight line basis over the terms of the leases. Rent expense was $16.2 million, $19.0 million and $22.5 million for the years ended December 31, 2016, 2017 and 2018, respectively.

Capital Leases and Deferred Financing Obligations

At December 31, 2017, aggregate future amounts of minimum payments under capital leases and deferred financing obligations, net of leasehold improvement allowances, were as follows: 2019—$8.9 million; 2020—$10.5 million; 2021—$3.9 million; 2022—$3.7 million; 2023—$3.7 million; 2024 and beyond—$3.8 million. Included in the future amounts payable under capital lease and deferred financing commitments is imputed interest of $3.3 million.

10. Business Segment Information

The accounting policies of the Company's segments are the same as those described in Note 2—"Summary of Significant Accounting Policies." The Company evaluates performance of its segments based on profit or loss from operations before stock compensation expense, depreciation and amortization, interest expense, interest and other income, changes in the fair value of contingent consideration recorded in relation to acquisitions, gain on sale of assets, special charges or benefits, and income taxes ("Segment Profit"). Management uses Segment Profit information for internal reporting and control purposes and considers it important in making decisions regarding the allocation of capital and other resources, risk assessment and employee compensation, among other matters. Healthcare subcontracts with Pharmacy Management to provide pharmacy benefits management services for certain of Healthcare's customers. In addition, Pharmacy Management provides pharmacy benefits management for the Company's employees covered under its medical plan. As such, revenue, cost of goods sold and direct service costs and other related to these arrangements are eliminated. The Company's segments are defined in Note 1—"General."

The following tables summarize, for the periods indicated, operating results by business segment (in thousands):

	Healthcare	Pharmacy Management	Corporate and Elimination	Consolidated
Year Ended December 31, 2016				
Managed care and other revenue	$ 2,659,685	$ 243,561	$ (304)	$ 2,902,942
PBM and dispensing revenue	—	2,053,188	(119,246)	1,933,942
Cost of care	(1,882,614)	—	—	(1,882,614)
Cost of goods sold	—	(1,933,086)	114,366	(1,818,720)
Direct service costs and other	(573,706)	(261,570)	(41,336)	(876,612)
Stock compensation expense (1)	4,440	20,509	12,473	37,422
Changes in fair value of contingent consideration (1)	(231)	127	—	(104)
Impairment of intangible assets (1)	4,800	—	—	4,800
Less: non-controlling interest segment profit (loss) (2)	(567)	—	(170)	(737)
Segment profit (loss)	$ 212,941	$ 122,729	$ (33,877)	$ 301,793
Identifiable assets by business segment (3)				
Restricted cash	$ 81,608	$ 1	$ 167	$ 81,776
Net accounts receivable	191,058	405,611	10,095	606,764
Investments	293,034	10,703	1,516	305,253
Pharmaceutical inventory	—	58,995	—	58,995
Goodwill	350,576	391,478	—	742,054

Other intangible assets, net	55,756	130,476	—	186,232

Table of Contents

	Healthcare	Pharmacy Management	Corporate and Elimination	Consolidated
Year Ended December 31, 2017				
Managed care and other revenue	$ 3,206,277	$ 273,489	$ (584)	$ 3,479,182
PBM revenue	—	2,491,044	(131,643)	2,359,401
Cost of care	(2,413,770)	—	—	(2,413,770)
Cost of goods sold	—	(2,341,979)	130,069	(2,211,910)
Direct service costs and other	(601,201)	(302,525)	(38,157)	(941,883)
Stock compensation expense (1)	10,689	19,881	8,546	39,116
Changes in fair value of contingent consideration (1)	696	—	—	696
Less: non-controlling interest segment profit (loss) (2)	(56)	—	(3)	(59)
Segment profit (loss)	$ 202,747	$ 139,910	$ (31,766)	$ 310,891
Identifiable assets by business segment (3)				
Restricted cash	$ 220,786	$ 8,059	$ 168	$ 229,013
Net accounts receivable	244,486	403,880	12,409	660,775
Investments	327,865	—	—	327,865
Pharmaceutical inventory	—	40,945	—	40,945
Goodwill	610,867	395,421	—	1,006,288
Other intangible assets, net	165,159	103,129	—	268,288

	Healthcare	Pharmacy Management	Corporate and Elimination	Consolidated
Year Ended December 31, 2018				
Managed care and other revenue	$ 4,638,622	$ 240,427	$ (607)	$ 4,878,442
PBM revenue	—	2,625,417	(189,708)	2,435,709
Cost of care	(3,762,412)	—	—	(3,762,412)
Cost of goods sold	—	(2,468,170)	185,148	(2,283,022)
Direct service costs and other	(735,366)	(298,713)	(37,456)	(1,071,535)
Stock compensation expense (1)	6,982	5,458	17,032	29,472
Changes in fair value of contingent consideration (1)	1,307	—	—	1,307
Segment profit (loss)	$ 149,133	$ 104,419	$ (25,591)	$ 227,961
Identifiable assets by business segment (3)				
Restricted cash	$ 157,437	$ 576	$ 2,954	$ 160,967
Net accounts receivable	290,564	465,345	150	756,059
Investments	378,706	7,037	—	385,743
Pharmaceutical inventory	—	40,818	—	40,818
Goodwill	622,604	395,552	—	1,018,156
Other intangible assets, net	136,644	82,072	13,167	231,883

(1)

Stock compensation expense, changes in the fair value of contingent consideration recorded in relation to the acquisitions and impairment of intangible assets are included in direct service costs and other operating expenses; however, these amounts are excluded from the computation of Segment Profit.

(2) The non-controlling interest portion of AlphaCare's segment profit (loss) is excluded from the computation of Segment Profit in 2016 and 2017.

(3) Identifiable assets by business segment are those assets that are used in the operations of each segment. The remainder of the Company's assets cannot be specifically identified by segment.

Table of Contents

The following table reconciles consolidated income before income taxes to Segment Profit for the years ended December 31, 2016, 2017 and 2018 (in thousands):

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

11. Selected Quarterly Financial Data (Unaudited)

The following is a summary of the unaudited quarterly results of operations for the years ended December 31, 2017 and 2018 (in thousands, except per share amounts):

	For the Quarter Ended			
	March 31, 2017	June 30, 2017	September 30, 2017	December 31, 2017
Year Ended December 31, 2017				
Net revenue:				
Managed care and other	$ 729,340	$ 821,699	$ 834,358	$ 1,093,785
PBM and dispensing	576,283	597,440	585,048	600,630
Total net revenue	1,305,623	1,419,139	1,419,406	1,694,415
Costs and expenses:				
Cost of care	482,054	583,264	569,306	779,146
Cost of goods sold	542,633	562,355	543,682	563,240
Direct service costs and other operating expenses (1) (2) (3)	221,486	231,372	227,372	261,653
Depreciation and amortization	26,976	27,731	28,189	32,810
Interest expense	4,148	4,900	7,663	9,266
Interest and other income	(949)	(1,071)	(1,781)	(2,086)
Total costs and expenses	1,276,348	1,408,551	1,374,431	1,644,029
Income before income taxes	29,275	10,588	44,975	50,386
Provision (benefit) for income taxes	11,806	5,661	11,739	(4,123)
Net income	17,469	4,927	33,236	54,509
Less: net income (loss) attributable to non-controlling interest	(278)	(573)	785	—
Net income attributable to Magellan	$ 17,747	$ 5,500	$ 32,451	$ 54,509
Weighted average number of common shares outstanding—basic	23,012	23,108	23,282	23,921

Weighted average number of common shares outstanding—diluted	24,038	24,038	24,563	25,113
Net income per common share attributable to Magellan:				
Net income per common share—basic:	$ 0.77	$ 0.24	$ 1.39	$ 2.28
Net income per common share—diluted:	$ 0.74	$ 0.23	$ 1.32	$ 2.17

Table of Contents

	For the Quarter Ended			
	March 31, 2018	June 30, 2018	September 30, 2018	December 31, 2018
Year Ended December 31, 2018				
Net revenue:				
Managed care and other	$ 1,219,763	$ 1,215,340	$ 1,235,787	$ 1,207,552
PBM and dispensing	585,314	595,583	617,719	637,093
Total net revenue	1,805,077	1,810,923	1,853,506	1,844,645
Costs and expenses:				
Cost of care	928,661	935,814	938,031	959,906
Cost of goods sold	559,665	558,419	571,145	593,793
Direct service costs and other operating expenses (3)(4)	269,077	259,152	265,471	277,835
Depreciation and amortization	30,407	33,848	33,047	35,358
Interest expense	8,366	8,678	8,990	9,362
Interest and other income	(2,476)	(3,363)	(4,139)	(4,090)
Total costs and expenses	1,793,700	1,792,548	1,812,545	1,872,164
Income (loss) before income taxes	11,377	18,375	40,961	(27,519)
(Benefit) provision for income taxes	(75)	4,824	13,816	448
Net income (loss) attributable to Magellan	11,452	13,551	27,145	(27,967)
Weighted average number of common shares outstanding—basic	24,349	24,569	24,433	24,048
Weighted average number of common shares outstanding—diluted	25,612	25,407	24,928	24,048
Net income (loss) per common share attributable to Magellan:				
Net income (loss) per common share—basic:	$ 0.47	$ 0.55	$ 1.11	$ (1.16)
Net income (loss) per common share—diluted:	$ 0.45	$ 0.53	$ 1.09	$ (1.16)

(1) Includes stock compensation expense of $10,140, $11,371, $10,323 and $7,282 for the quarters ended March 31, June 30, September 30 and December 31, 2017, respectively.
(2) Includes changes in fair value of contingent consideration of $(49), $252, $(834) and $1,327 for the quarters ended March 31, June 30, September 30 and December 31, 2017, respectively.
(3) Includes stock compensation expense of $7,646, $10,439, $9,320 and $2,067 for the quarters ended March 31, June 30, September 30 and December 31, 2018, respectively.
(4) Includes changes in fair value of contingent consideration of $233, $70, $148 and $856 for the quarters ended March 31, June 30, September 30 and December 31, 2018, respectively.