MAGELLAN HEALTH INC
Form 10-K
February 26, 2015

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

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

For the fiscal year ended December 31, 2014

o **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 400 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: **None.**

Title of Each Class	**Name of Each Exchange on which Registered**
Ordinary 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 ý No o

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

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 ý No o

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

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ý	Accelerated filer o	Non-accelerated filer o (Do not check if a smaller reporting company)	Smaller reporting company o

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

The aggregate market value of the Ordinary Common Stock ("common stock") held by non-affiliates of the registrant based on the closing price on June 30, 2014 (the last business day of the registrant's most recently completed second fiscal quarter) was approximately $1.8 billion.

The number of shares of Magellan Health, Inc.'s common stock outstanding as of February 23, 2015 was 26,665,409.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the definitive proxy statement for the 2015 Annual Meeting of Shareholders are incorporated by reference into Part III of this Form 10-K.

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MAGELLAN HEALTH, INC.

REPORT ON FORM 10-K

For the Fiscal Year Ended December 31, 2014

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PART I

Cautionary Statement Concerning Forward-Looking Statements

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

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

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

Item 1. Business

Magellan Health, Inc. ("Magellan") was incorporated in 1969 under the laws of the State of Delaware. Magellan's executive offices are located at 4800 Scottsdale Road, Suite 4400, Scottsdale, Arizona 85251, and its telephone number at that location is (602) 572-6050. References in this report to the "Company" include Magellan and its subsidiaries.

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 managed care organizations ("MCOs"), employers, labor unions, various military and governmental agencies, third party administrators, consultants and brokers. The Company's business is divided into the following five segments, based on the services it provides and/or the customers that it serves, as described below.

Managed Healthcare

Two of the Company's segments are in the managed healthcare business. This line of business reflects the Company's: (i) management of behavioral healthcare services, and (ii) the integrated management of physical, behavioral and pharmaceutical healthcare for special populations, delivered through Magellan Complete Care ("MCC"). The Company's coordination and management of physical and behavioral healthcare includes services provided through its comprehensive network of medical and

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behavioral health professionals, clinics, hospitals and ancillary service providers. This network of credentialed and privileged providers is integrated with clinical and quality improvement programs to enhance the healthcare experience for individuals in need of care, while at the same time managing the cost of these services for our customers. The treatment services provided through the Company's provider network include outpatient programs, intermediate care programs, inpatient treatment and crisis intervention services. 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's integrated management of physical and behavioral healthcare includes full service health plans which provide for the holistic management of special populations. These special populations include individuals with serious mental illness ("SMI"), those covered under both Medicare and Medicaid (dual eligibles), those eligible for long term care and other populations with unique and often complex healthcare needs.

The Company provides its 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, (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 responsibility for the cost of the treatment services, and (iii) employee assistance programs ("EAPs") where the Company provides short-term outpatient behavioral counseling services.

The managed healthcare business includes the following two segments, which are differentiated based on the services provided and/or the customers served:

Commercial. The Managed Healthcare Commercial segment ("Commercial") generally reflects managed behavioral healthcare services and EAP services provided under contracts with health plans, insurance companies and MCOs for some or all of their commercial, Medicaid and Medicare members, as well as with employers, including corporations, governmental agencies, military and labor unions. Commercial's contracts encompass risk-based, ASO and EAP arrangements. As of December 31, 2014, Commercial's covered lives were 2.7 million, 14.3 million and 13.3 million for risk-based, ASO and EAP products, respectively. For the year ended December 31, 2014, Commercial's revenue was $362.6 million, $127.0 million and $184.4 million for risk-based, ASO and EAP products, respectively.

Public Sector. The Managed Healthcare Public Sector segment ("Public Sector") generally reflects: (i) the management of behavioral health services provided to recipients under Medicaid and other state sponsored programs under contracts with state and local governmental agencies, and (ii) the integrated management of physical, behavioral and pharmaceutical care for special populations covered under Medicaid and other government sponsored programs. Public Sector contracts encompass either risk-based or ASO arrangements. As of December 31, 2014, Public Sector's covered lives were 1.4 million and 1.8 million for risk-based and ASO products, respectively. For the year ended December 31, 2014, Public Sector's revenue was $1.6 billion and $55.6 million for risk-based and ASO products, respectively.

Specialty Solutions

The Specialty Solutions segment ("Specialty Solutions") generally reflects the management of the delivery of diagnostic imaging (radiology benefits management or "RBM") and a variety of other specialty areas such as radiation oncology, obstetrical ultrasound, cardiology and musculoskeletal management to ensure that such services are clinically appropriate and cost effective. The Company's Specialty Solutions services are currently provided under contracts with health plans and insurance companies for some or all of their commercial, Medicaid and Medicare members. The Company also contracts with state and local governmental agencies for the provision of such services to Medicaid

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recipients. The Company offers its Specialty Solutions services through risk-based contracts, where the Company assumes all or a substantial portion of the responsibility for the cost of providing services, and through ASO contracts, where the Company provides services such as utilization review and claims administration, but does not assume responsibility for the cost of the services. As of December 31, 2014, covered lives for Specialty Solutions were 6.5 million and 14.2 million for risk-based and ASO products, respectively. For the year ended December 31, 2014, revenue for Specialty Solutions was $423.6 million and $47.7 million for risk-based and ASO products, respectively.

Pharmacy Management

The Pharmacy Management segment ("Pharmacy Management") comprises products and solutions that provide clinical and financial management of drugs paid under medical and pharmacy benefit programs. Pharmacy Management's services include (i) traditional pharmacy benefit management ("PBM") services; (ii) pharmacy benefit administration ("PBA") for state Medicaid and other government sponsored programs; (iii) specialty pharmaceutical dispensing operations, contracting and formulary optimization 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. In addition, Pharmacy Management has subcontract arrangements to provide PBM services for certain Public Sector customers.

The Company's Pharmacy Management programs are provided under contracts with health plans, employers, Medicaid MCOs, state Medicaid programs, and other government agencies, and encompass risk-based and fee-for-service ("FFS") arrangements. During 2014, Pharmacy Management paid 9.5 million adjusted commercial network claims in the Company's PBM business. As of December 31, 2014, the Company had a generic dispensing rate of 83.6 percent within its commercial PBM business. In addition, during 2014, the Company paid 68.5 million adjusted PBA claims and 0.1 million specialty dispensing claims. Adjusted claim totals apply a multiple of three for each 90-day and traditional mail claim. In addition, as of December 31, 2014, Pharmacy Management served 0.8 million commercial PBM members, 9.6 million members in its medical pharmacy management programs, and 25 states and the District of Columbia in its PBA business.

Corporate

This segment of the Company is comprised primarily of operational support functions such as sales and marketing and information technology, as well as corporate support functions such as executive, finance, human resources and legal.

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

Acquisition of Partners Rx Management LLC

Pursuant to the September 6, 2013 Agreement and Plan of Merger (the "Merger Agreement") with Partners Rx Management, LLC ("Partners Rx"), on October 1, 2013 the Company acquired all of the outstanding ownership interests of Partners Rx. Partners Rx is a full-service commercial PBM with a strong focus on health plans and self-funded employers primarily through sales through third party administrators, consultants and brokers. As consideration for the transaction, the Company paid $99.3 million in cash, including net receipts of $0.7 million for working capital adjustments. The Company funded the acquisition with cash on hand.

For further discussion, see Note 3 "Acquisitions" to the consolidated financial statements set forth elsewhere herein.

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Acquisition of AlphaCare Holdings, Inc.

Pursuant to the August 13, 2013 stock purchase agreement (the "Stock Purchase Agreement"), on December 31, 2013 the Company acquired a 65% equity interest in AlphaCare Holdings, Inc. ("AlphaCare Holdings"), the holding company for AlphaCare New York, Inc. ("AlphaCare"), a Health Maintenance Organization ("HMO") in New York that operates a New York Managed Long-Term Care Plan "(MLTCP") in Bronx, New York, Queens, Kings and Westchester Counties, and Medicare Plans in Bronx, New York, Queens and Kings Counties.

Prior to December 31, 2013, the Company held a 7% equity interest in AlphaCare through a previous equity investment of $2.0 million in preferred membership units of AlphaCare's previous holding company, AlphaCare Holdings, LLC on May 17, 2013. The Company also previously loaned $5.9 million to AlphaCare Holdings, LLC. As part of the Stock Purchase Agreement, AlphaCare Holdings, LLC was reorganized into a Delaware corporation, and on December 31, 2013 the preferred membership units and the loan were converted into Series A Participating Preferred Stock ("Series A Preferred") of AlphaCare Holdings and the Company purchased an additional $17.4 million of Series A Preferred. During 2014, the Company purchased $2.2 million in common shares from the minority owners of AlphaCare. During 2014, the Company also purchased an additional $8.9 million in shares of Series B Participating Preferred Stock and Series C Participating Preferred Stock issued by AlphaCare Holdings. As of December 31, 2014, the Company held a 75% voting interest and the remaining shareholders held a 25% voting interest in AlphaCare Holdings.

Based on the Company's 75% equity and voting interest in AlphaCare Holdings, the Company has included the results of operations in its consolidated financial statements. The Company reports the results of operations of AlphaCare Holdings within the Public Sector segment.

For further discussion, see Note 3 "Acquisitions" to the consolidated financial statements set forth elsewhere herein.

Acquisition of CDMI, LLC

Pursuant to the March 31, 2014 purchase agreement (the "CDMI Agreement") with CDMI, LLC ("CDMI") on April 30, 2014 the Company acquired all of the outstanding equity interests of CDMI. CDMI provides a range of clinical consulting programs and negotiates and administers drug rebates for managed care organizations and other customers. As consideration for the transaction, the Company paid a base price of $201.1 million, including net receipts of $3.9 million for working capital adjustments. Pursuant to the CDMI Agreement, the sellers and certain key management of CDMI purchased a total of $80.0 million in Magellan restricted common stock, which will generally vest over a 42-month period, conditioned upon continued employment. In addition to the base purchase price, the CDMI Agreement provides for potential contingent payments up to a maximum aggregate amount of $165.0 million. The potential future payments are contingent upon CDMI meeting certain client retention, client conversion, and gross profit milestones through December 31, 2016.

The Company reports the results of operations of CDMI within its Pharmacy Management segment.

For further discussion, see Note 3 "Acquisitions" to the consolidated financial statements set forth elsewhere herein.

Other Acquisitions

Pursuant to the July 1, 2014 purchase agreement (the "Cobalt Agreement") with Cobalt Therapeutics, LLC ("Cobalt"), the Company acquired all of the outstanding equity interests of Cobalt. Cobalt provides computerized cognitive behavioral therapy self-service programs. As consideration for the transaction, the Company paid a base price of $8.0 million in cash, subject to working capital

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adjustments. In addition to the base purchase price, the Cobalt Agreement provides for potential contingent payments up to a maximum aggregate amount of $6.0 million. The potential future payments are contingent upon engagement of new members and new contract execution through June 30, 2017. The purchase price has been allocated based upon the estimated fair value of net assets acquired at the date of acquisition. The Company will make appropriate adjustments to the purchase price allocations prior to the completion of the measurement period as required.

The Company reports the results of operations of Cobalt within its Commercial segment.

For further discussion, see Note 3 "Acquisitions" to the consolidated financial statements set forth elsewhere herein.

Industry

According to the Centers for Medicare and Medicaid Services ("CMS"), U.S. healthcare spending was projected to have increased 5.6 percent to $3.1 trillion in 2014, representing nearly 17.6 percent of the gross domestic product. With the uncertain economic environment, rising healthcare costs, increased fiscal pressures on federal and state governments, and the uncertainty around the full implementation 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.

Over the last several years, the Company has transformed itself into a healthcare management business focused on meeting needs in areas of healthcare that are fast growing, highly complex and high cost, with an emphasis on special populations with complex care needs.

Business Strategy

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. It currently provides managed behavioral healthcare, specialty solutions, and pharmacy management services as well as integrated healthcare management for special populations. The Company's strategy is to expand its integrated management programs for special populations, expand its pharmacy management business, and further grow its other existing businesses. The Company believes that certain of its clients may prefer to consolidate outsourced vendors, and that as a vendor offering multiple outsourced products, it will have a competitive advantage in the market. The Company seeks to grow its managed healthcare business through the following initiatives:

Expanding integrated management services provided to special populations through its Magellan Complete Care business. The Company, through Magellan Complete Care, seeks to expand its focus on the clinically integrated management of complex populations including individuals with SMI, dual-eligibles, those eligible for long-term care, and other unique, high-cost populations. These programs holistically manage the behavioral and physical health care, including drug spend, of special populations and utilize the Company's unique expertise to improve health outcomes and lower costs. The Company believes its significant Medicaid, behavioral health and pharmacy experience will enable it to further develop and market programs to manage these special populations. The Company is developing independent special population management capabilities and may enter into partnerships, joint ventures, or acquisitions that facilitate this effort. The Company believes it is positioned to grow its membership and revenues in the integrated care management of special populations over the long term.

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Expanding the Pharmacy Management business. The Company has operated in both the specialty pharmaceutical management and Medicaid pharmacy benefits management businesses for several years and acquired a commercial pharmacy benefit management company in October of 2013. The Company has integrated all of these businesses, leveraging their strength and assets, and has built out its commercial pharmacy benefit management capabilities in order to expand its presence in the pharmaceutical marketplace. This business segment offers clinical and financial management solutions that help customers manage the quality and cost of pharmaceutical care for any drug, under any benefit, at any site of service. Pharmacy Management provides a comprehensive suite of solutions, including traditional pharmacy benefit management; pharmacy benefit administration for state Medicaid and other government sponsored programs; specialty pharmacy solutions including formulary and rebate management solutions and specialty dispensing; and its medical pharmacy management product, which manages the cost and quality of therapeutic interventions for complex conditions covered under the medical benefit. These products are available individually, in combination, or in a fully integrated manner. The Company is marketing its pharmacy management products to existing and new health plans, employer groups, state governments, exchanges, Medicaid managed care organizations, third party administrators, brokers and consultants. The Company continues to cross-sell Pharmacy Management products to its other segments' customer base.

Continued growth in our other existing businesses. The Company has operated in both the commercial and public sectors of managed behavioral healthcare by ensuring the delivery of quality outcomes and appropriate care through its unique behavioral healthcare expertise in managing clinical care, provider networks, claims, and customer service. The Company focuses on continually developing and providing innovative and cost effective solutions to its customers, and expanding into new markets. Through its Commercial behavioral segment, the Company seeks to provide a superior outsourced behavioral health management alternative to its health plan, employer, and government customers. The Company has expanded its product offerings including population health solutions for Autism Spectrum Disorders, caregivers, managed long term care, military, seriously mentally ill, suicide prevention, child welfare programs and computerized cognitive behavioral therapy. Through its Public Sector segment, the Company seeks to help state and local governments deal with their fiscal pressures resulting from increasing Medicaid enrollment and rising behavioral healthcare costs. The Company intends to continue marketing both its risk-based and ASO products, as well as new products, to its existing customer base and new customers, and to cross-sell its behavioral product portfolio to its other segments' customer base.

In Specialty Solutions, the Company's strategy is to deliver innovative and clinically appropriate management programs that create value for its clients through the reduction in the number of inappropriate services and by ensuring the delivery of appropriate services through quality providers. The Company seeks to distinguish itself in the marketplace through a focus on clinical excellence, provider partnerships, product and service innovation, and consumer engagement. The Company continues to expand its product portfolio beyond diagnostic imaging with customer-focused solutions in new areas of medical management including radiation oncology therapy management, cardiac management, obstetrical ultrasound management, musculoskeletal management, genetic testing, and other relevant areas. In addition to selling its programs to new customers, the Company's growth strategy is also focused on continuing to develop innovative new products and to expand membership with current customers, upsell additional products to existing customers, and cross-sell to its other segments' customer base.

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

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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 60 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 "Risk Factors Risk-Based Products" and " Reliance on Customer Contracts."

The Company's contract with the State of Arizona as the Regional Behavioral Health Authority in Maricopa County (the "Maricopa Contract") generated net revenues that exceeded, in the aggregate, ten percent of net revenues for the consolidated Company for the year ended December 31, 2013. The Maricopa Contract terminated on March 31, 2014. The Company provides behavioral healthcare management and other related services to members in the state of Iowa pursuant to contracts with the State of Iowa (the "Iowa Contracts"). The Iowa Contracts generated net revenues that exceeded, in the aggregate, ten percent of net revenues for the consolidated Company for the year ended December 31, 2014.

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. See further discussion related to these significant customers in "Risk Factors Reliance on Customer Contracts." In addition, see "Risk Factors Dependence on Government Spending" for discussion of risks to the Company related to government contracts.

Provider Network

The Company's managed behavioral healthcare services, integrated healthcare services and EAP treatment services are provided by a contracted network of third-party providers, including physicians, psychiatrists, psychologists, other behavioral and physical health professionals, psychiatric hospitals, general medical facilities with psychiatric beds, residential treatment centers and other treatment facilities. 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 155,000 healthcare providers, including facility locations, 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 include both individual practitioners, as well as individuals who are members of group practices or other licensed centers or programs. Non-facility network providers typically execute standard contracts with the Company under which they are generally paid on a fee-for-service basis.

Third-party network facilities include inpatient psychiatric and substance abuse hospitals, intensive outpatient facilities, partial hospitalization facilities, community health centers and other community-based facilities, rehabilitative and support facilities and other intermediate care and alternative care facilities or programs. This variety of facilities enables the Company to offer patients a full continuum of care and to refer patients to the most appropriate facility or program within that continuum. Typically, 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.

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The Company's RBM services are provided by a network of providers including diagnostic imaging centers, radiology departments of hospitals that provide advanced imaging services on an outpatient basis, and individual physicians or physician groups that own advanced imaging equipment and specialize in certain specific areas of care. Certain providers belong to the Company's network, while others are members of networks belonging to the Company's customers. These providers are paid on a fee-for-service basis.

Competition

The Company's business is highly competitive. The Company competes with other healthcare organizations as well as with insurance companies, including HMOs, preferred provider organizations ("PPOs"), third-party administrators ("TPAs"), independent practitioner associations ("IPAs"), multi-disciplinary medical groups, PBMs, healthcare information technology solutions, 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 in 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 subscribers, rather than by contracting 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, 2014 to June 17, 2015. 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, 2014 to June 17, 2015. 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 maintains separate professional liability insurance policies with unaffiliated insurers for its Maricopa Contract business for the behavioral health direct care facilities, all of which were divested at various times prior to September 1, 2009. The Maricopa Contract professional liability insurance policies effective dates were from September 1, 2008 to September 1, 2009. The Company purchased a five-year extended reporting period for the professional liability policies effective September 1, 2009 for the period September 1, 2009 to September 1, 2014, subject to a $0.5 million per claim un-aggregated self-insured retention. The Company extended the reporting period for the professional liability policies for an additional two-year period to September 1, 2016, subject to a $0.5 million per claim un-aggregated self-insured retention. The professional liability policies are written on a "claims-made" basis.

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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 "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. The Company believes its operations are structured to comply in all material respects with applicable laws and regulations and that it has obtained all licenses and approvals that are material to the operation of its business. However, regulation of the healthcare industry 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 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. Moreover, any such position 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 affect 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. In addition, the Company is subject to certain federal laws and regulations, including federal laws and regulations in connection with its role in managing its customers' employee benefit plans, Medicaid, Medicare, health insurance and laws and regulations impacting federal government contracts.

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.

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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 Part D business; this is discussed further in the pharmacy section of this document. 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, mandated benefits, rate setting 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 (the "NAIC") has developed a "health organizations risk-based capital" formula, designed specifically for managed care organizations, that establishes a minimum amount of 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, requiring additional restricted cash or other security.

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The licensing process under state insurance laws can be lengthy and the Company could experience a material adverse effect on its operating results and financial condition while its license applications are pending as we apply for new licenses to support business growth. In addition, 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 such 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 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 duty to warn others of danger or to prevent patient self-injury. 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.

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. The Company believes that its operations as currently conducted are in compliance with the applicable laws. However, 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 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

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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 utilization review, TPA and PBM 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 utilization review or TPA activities. In some states, the Company has licensed its self-funded pharmacy related business as a TPA 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. The Company believes that it is in compliance with ERISA and that such compliance does not currently have a material adverse effect on its operations. However, 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 requires the Secretary of the Department of Health and Human Services ("HHS") to adopt 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. Oversight responsibilities for HIPAA compliance are handled by the Company's Corporate Compliance Department. The Company believes it is currently in compliance with the provisions of HIPAA.

The Health Information Technology for Economic and Clinical Health Act ("HITECH Act") passed as part of the American Recovery and Reinvestment Act of 2009 represents a significant expansion of the HIPAA privacy and security laws. The HITECH Act provisions contain multiple effective dates. The Company believes it is currently in compliance with those provisions of the HITECH Act and associated regulations that are currently in effect including the January 2013 "Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act" Rule, and will be in compliance with those portions of the law and regulations that become effective in the future. The Company believes that it can comply with future changes in these laws and regulations; however, there can be no assurance that compliance with such future laws and regulations would not have a material adverse effect on its operations.

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The privacy regulation under HIPAA generally does not preempt state law except under the following limited circumstances: (i) the privacy rights afforded under state law are contrary to those provided by HIPAA so that compliance with both standards is not possible and (ii) HIPAA's privacy protections are more stringent than the state law in question. Because many states have privacy laws that either provide more stringent privacy protections than those imposed by HIPAA or laws that can be followed in addition to HIPAA, the Company must address privacy issues under HIPAA and state law as well. The Company believes it is in compliance with all applicable state laws governing privacy and security.

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 Company believes that it is currently in compliance with these applicable laws and regulations.

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 health care 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") within the U.S. Department of Health and Human Services ("DHHS"), and other administrative bodies.

It also is a crime under the Public Contracts Anti-Kickback Statute, for any person to knowingly and willfully offer or provide any remuneration to a prime contractor to the United States, including a contractor servicing federally funded health programs, 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, at the state and federal level, by pharmacy benefit managers 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 health care program, such as Medicare or Medicaid, in order to influence the beneficiary's choice of a provider. For example, our HMO and specialty pharmacy business are subject to the CMP statute.

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.

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The Federal Civil False Claims Act imposes civil penalties for knowingly making or causing to be made false claims with respect to 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 against providers 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 errors. 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 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 written policies are to be disseminated to all employees, contractors and agents which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid healthcare items or services, performs billing or coding functions, or is involved in the monitoring of healthcare provided by the entity. In addition, any such entity that has an employee handbook must include a specific discussion of the federal and state false claims laws, the rights of an employee to be protected as a whistleblower and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

On July 21, 2010, the President of the United States signed into law *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. On May 25, 2011, the SEC adopted final rules (the "Rules") for the expanded whistleblower program established by Dodd-Frank. The Company believes it is in compliance with these Rules.

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 believes that it is in substantial compliance with the legal requirements imposed by such laws and regulations. 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.

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, and the Company believes it is in substantial compliance with the legal requirements imposed by all of these laws and regulations. However, there can be no assurance that the Company will not be subject

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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

In October 2008, the United States Congress passed the Paul Wellstone and Pete Domenici 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 State Children's Health Insurance Program ("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 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. The Health Insurance Exchange regulations provide that plans offered on the exchange must offer behavioral health benefits that are compliant with federal parity law. 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. The Final Rules affirmed the content of the IFR with a few changes and some additional clarifications on the regulator's intent. The Company believes it is in compliance with the requirements of the IFR and the Final Rules. The Company anticipates that a parity regulation relating to Managed Medicaid business will be released in 2015. 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.

Health Care Reform

The ACA is a broad and sweeping piece of legislation creating numerous changes in the healthcare regulatory environment. To date, numerous regulations implementing provisions of the ACA have been released in addition to many requests for information, frequently asked questions and other informational notices. Some of these regulations, 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 behavioral health and radiology 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 new plans. The

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Supreme Court will decide the issue of continuing to allow premium tax credits for enrollees in the states that have federally facilitated exchanges. If these credits are no longer permitted in the federally facilitated exchanges it will impact customers of the Company that are participating in these exchanges and the Company as a vendor to 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 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 is uncertain. 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. The Company believes it is in compliance with these laws, regulations, and contractual requirements.

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.

In connection with its specialty pharmacy business, the Company negotiates rebates with and provides services for drug manufacturers, which 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 the CMS as a Medicare Advantage Organization 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 its contractors' performance to determine compliance with contracts and CMS regulations, and to assess the quality of services provided to Medicare beneficiaries. The Company believes it substantially complies with all applicable federal laws, regulations and contractual requirements. However, CMS penalties for non-compliance include premium refunds, prohibiting a company from continuing to market and/or enroll members in the company's Medicare product, exclusion for participation in federally funded healthcare programs and other sanctions.

The Company is also subcontractor to health plans that are Medicare Advantage Organizations and Medicare Prescription Drug Plans ("PDP") and provide benefits to Medicare beneficiaries. In the Company's capacity as a subcontractor with these health plans, the Company is indirectly subject to

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certain federal laws and regulations as well as contractual requirements pertaining to the operation of this business. If the 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 subcontracts, the Company can give no assurances that CMS or a health plan will not terminate the Company's business relationships insofar as they pertain to these services.

The Company was approved by CMS to operate a Medicare PDP with respect to employer/union groups, beginning January 1, 2015. The Company has also applied to CMS to operate a PDP and offer Medicare Part D benefits to individual eligible beneficiaries in various CMS Regions. CMS has issued significant interpretive regulations and guidance regarding PDPs to which the Company is directly subject. If CMS determines that the Company has not performed satisfactorily, CMS may require the Company to cease its Part D activities or responsibilities under the contract. The Company can give no assurance as to whether its application will be approved. However, the Company believes that it will be in compliance with these requirements if approval is obtained and business operations commence.

Moreover, in relation to its pharmaceutical management business, the Company contracts with PDPs and MA-PD plans (collectively, "Part D Plans") to provide various services. In the Company's capacity as a subcontractor with certain Part D Plan clients, the Company is subject to certain federal rules, regulations, and sub-regulatory guidance pertaining to the operation of Medicare Part D. If CMS or a Part D Plan determines that the Company has not performed satisfactorily as a subcontractor, CMS or the Part D Plan may require the Company to cease its Part D 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 CMS or a Part D Plan will not terminate the Company's business relationships insofar as they pertain to Medicare Part D.

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 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 limit 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.

Other Federal and State Laws and Regulations

Federal Laws and Regulations affecting Procurement. 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 and may impose added costs on its business. The Company's failure to comply with federal proc