MAGELLAN HEALTH INC
Form 10-K
February 29, 2016

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Table of Contents

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, 2015

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 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: **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, 2015 (the last business day of the registrant's most recently completed second fiscal quarter) was approximately $1.9 billion.

The number of shares of Magellan Health, Inc.'s common stock outstanding as of February 24, 2016 was 24,716,357.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the definitive proxy statement for the 2016 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, 2015

Table of Contents

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") 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 managing the fastest growing, most complex areas of health, 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 health outcomes and optimize the cost of care for the members 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").

Effective as of July 1, 2015, the Company reorganized into two business units Magellan Healthcare and Magellan Rx Management, which are supported by corporate functions. As a result of this business reorganization, the Company concluded that changes to its reportable segments were warranted, with the Healthcare segment ("Healthcare") comprised of the operating segments previously defined as the Commercial, Public Sector and the Specialty Solutions segments. Prior period balances

Table of Contents

have been reclassified to reflect this change. The Company's business is divided into the following segments, which are differentiated based on the services it provides, as described below.

Healthcare

Healthcare includes the Company's: (i) management of behavioral healthcare services and employee assistance program ("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 ("MCC"). These special populations include individuals with serious mental illness ("SMI"), dual eligibles, long-term services and supports and other populations with unique and often complex healthcare needs.

The Company's coordination and management of these healthcare services are provided through its comprehensive network of medical and 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 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. 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 Healthcare segment's commercial division serves a variety of customers, with services, inclusive of special population management, provided under contracts with health plans and accountable care organizations for some or all of their commercial, Medicaid and Medicare members, as well as with employers. The government division contracts with local, state and federal governmental agencies to provide services to recipients under Medicaid, Medicare and other government programs.

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 and (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.

The following tables summarize, for the periods indicated, revenues and covered lives for Healthcare by product classification and customer type (in thousands):

	Revenue for the year ended December 31, 2015		
	Risk-based	**ASO**	**Total**
Commercial			
Behavioral(1)	$ 326,182	$ 127,270	$ 453,452
Specialty	523,701	58,564	582,265
Government(2)	1,855,225	68,310	1,923,535
Total	$ 2,705,108	$ 254,144	$ 2,959,252

Table of Contents

	Covered lives as of December 31, 2015	
	Risk-based	ASO
Commercial		
Behavioral(1)	13,019	12,513
Specialty	8,320	15,884
Government(2)	4,819	1,080

(1) Includes revenues of $49.5 million from EAP services provided on a risk basis to health plans and employers with 10.5 million covered lives.

(2) Includes revenues of $155.3 million from EAP services provided on a risk basis to federal governmental entities with 3.6 million covered lives.

Pharmacy Management

The Pharmacy Management segment ("Pharmacy Management") 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) pharmacy benefit management ("PBM") services; (ii) pharmacy benefit administration ("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 across both the medical and pharmacy benefit that treat complex conditions, regardless of site of service, method of delivery, or benefit reimbursement.

Pharmacy Management's services are provided under contracts with health plans, employers, MCOs, state Medicaid programs, Medicare Part D and other government agencies, and encompass risk-based and fee-for-service ("FFS") arrangements. In addition, Pharmacy Management has subcontract arrangements to provide PBM services for certain Healthcare customers. During 2015, Pharmacy Management paid 18.8 million adjusted commercial network claims in its PBM business, 59.2 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. As of December 31, 2015, Pharmacy Management had a generic dispensing rate of 84.3 percent within its commercial PBM business and served 1.6 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 4D Pharmacy Management Systems, Inc.

Pursuant to the March 17, 2015 Purchase Agreement (the "4D Agreement") with 4D Pharmacy Management Systems, Inc. ("4D"), on April 1, 2015 the Company acquired (the "4D Acquisition") all of the outstanding equity interests of 4D. 4D was a privately held, full-service PBM serving MCOs, employers and government-sponsored benefit programs, such as Medicare Part D plans.

As consideration for the 4D Acquisition, the Company paid $55 million in cash, subject to working capital adjustments. There are additional potential contingent payments up to an aggregate amount of

$30 million. The contingent payment provisions provide for (i) cash payments of up to $10 million based on the achievement of certain growth targets in the underlying dual eligible membership served by 4D during calendar year 2015 and (ii) cash payments of up to $20 million for retention of certain business through 2018.

The Company reports the results of operations of 4D 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 January 15, 2015 purchase agreement (the "HSM Agreement") with HSM Physical Health, Inc. ("HSM") and HSM Companies Inc., on January 31, 2015 the Company acquired all of the outstanding equity interests of HSM. HSM provides cost containment and utilization management services focused on physical and musculoskeletal health specialties. As consideration for the transaction, the Company paid a base price of $13.6 million in cash, including net payments of $0.1 million for working capital adjustments. The Company reports the results of operations of HSM within its Healthcare 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"), total U.S. healthcare spending was projected to have increased 5.3 percent to nearly $3.2 trillion in 2015, representing approximately 17.7 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 that is focused on managing the fastest growing, most complex areas of health, including special populations, complete pharmacy benefits and other specialty areas of healthcare.

Business Strategy

The Company is engaged in the healthcare management business, and is focused on managing the fastest growing, most complex areas of health, including special populations, complete pharmacy benefits and other specialty areas of health. The Company develops innovative solutions that combine advanced analytics, agile technology and clinical excellence to drive better decision making, positively impact health outcomes and optimize the cost of care for the members it serves. The Company currently provides managed healthcare services, which includes the integrated management of physical, behavioral and pharmaceutical healthcare for special populations, and the management of behavioral healthcare and other specialty areas, as well as pharmacy management services. 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 behavioral healthcare and other specialty business. 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 business through the following initiatives:

Expanding integrated management services provided to special populations through Magellan Complete Care. 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 services and supports, 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.

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 2013, and additional pharmacy companies in 2014 and 2015. The Company has integrated 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. The Pharmacy Management business comprises products and solutions that provide clinical and financial management of pharmaceuticals paid under medical and pharmacy management programs. Pharmacy Management is a full service PBM that provides a comprehensive suite of solutions, including pharmacy benefit management; pharmacy benefit administration for state Medicaid and other government sponsored programs; pharmaceutical dispensing operations; clinical and formulary management programs; medical pharmacy management programs; and 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 is marketing its pharmacy management services to existing and new health plans, employers, 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.

Continued growth in our other existing behavioral healthcare and other specialty business. 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 seeks to distinguish itself in the marketplace through a focus on clinical excellence, provider partnerships, product and service innovation, and consumer engagement. In addition, the Company focuses on continually developing and providing innovative and cost effective solutions to its customers, and expanding into new markets.

Within its Healthcare segment, the commercial division is focused on providing managed behavioral services that seek 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, seriously mentally ill, suicide prevention, child welfare programs and computerized cognitive behavioral therapy. The commercial division also encompasses the management of specialty services in which 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

Table of Contents

inappropriate services and by ensuring the delivery of appropriate services through quality providers. 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. Through the government division of its Healthcare segment, the Company seeks to help federal, state and local governments deal with their fiscal pressures resulting from increasing Medicaid enrollment and rising behavioral healthcare costs. Across the Healthcare segment, 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, expand membership with current customers, upsell additional products to existing customers, and to cross-sell services to its Pharmacy Management segment 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 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."

Through December 31, 2015, the Company provided 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 years ended December 31, 2014 and 2015. The Iowa Contracts terminated on December 31, 2015. 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 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 165,000 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'

Table of Contents

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.

The Company's radiology benefits management ("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 health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), 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 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 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, 2015 to June 17, 2016. 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.

Table of Contents

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, 2015 to June 17, 2016. 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.

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. 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. 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

Table of Contents

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 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, coverage, mandated benefits, rate setting, grievances and appeals 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.

Table of Contents

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.

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 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 utilization review, PBM 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

Table of Contents

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 ("DHHS") 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 Company believes it is currently in compliance with the provisions of the HITECH Act and the associated regulations 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. The Company believes that it can comply with any future changes or updates 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.

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. 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.

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, furnish, or otherwise authorize the furnishing of, Medicaid healthcare items or services, perform billing or coding functions, or are 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 substantial compliance with these laws.

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 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. 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

Table of Contents

parity regulation relating to Managed Medicaid business will be released in 2016. 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 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 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. 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 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. 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.

Table of Contents

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 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 noncompliance include premium refunds, prohibiting a company from continuing to market and/or enroll members in the company's Medicare products, exclusion for participation in federally funded healthcare programs and other sanctions.

The Company is also 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 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.

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 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 believes that it is in compliance with all

Table of Contents

applicable laws and regulations and that such compliance does not currently have a material adverse effect on its operations.

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. The Company believes it is in substantial compliance with various federal regulations and in compliance with contract provisions relating to the services provided by a commercial organization.

Federal PBM Transparency Laws. Pursuant to the ACA, companies may participate in state and federally run health insurance exchanges. The Company has contracted to provide services to certain health insurance exchange products offered by insurers and may be subject to certain financial transparency and disclosure requirements. The ACA mandates that pharmacy benefit managers provide financial transparency and reporting in connection with Medicare Part D plans, as well as plans offered through exchanges. In the event that the Company is determined to be subject to these requirements, the Company does not anticipate that such requirements will have a materially adverse effect on the Company's business.

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 pharmaceutical management business of the Company. Legislation in this area is varied and encompasses licensing, audit provisions, 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 be having 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

Table of Contents

of by check. The shorter time 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 Prices. 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, CMS and several states have taken an interest in attempting to determine the "actual acquisition costs" of pharmacies. In 2012, CMS began conducting surveys and releasing preliminary data on pharmacy acquisition costs. At this time, the Company does not anticipate that actual acquisition cost surveys or pricing could 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.

Regulations Affecting the Company's Pharmacies. The Company owns two 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 New York and are duly licensed to conduct business in those states. Many 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.

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.

Employees of the Registrant

At December 31, 2015, the Company had approximately 6,900 full-time and part-time employees. The Company believes it has satisfactory relations with its employees.

Table of Contents

History

Magellan was incorporated in 1969 under the laws of the State of Delaware. The Company is engaged in the healthcare management business. Through 2005, the Company predominantly operated in the managed behavioral healthcare business. As a result of certain acquisitions and material growth since 2005, the Company expanded into integrated healthcare management, and is focused on managing the fastest growing, most complex areas of health, including special populations, complete pharmacy benefits and other specialty areas of healthcare.

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 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 63.1 percent, 52.2 percent and 50.0 percent of the Company's net revenue in the years ended December 31, 2013, 2014 and 2015, 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.

Table of Contents

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. Other of the Company's customers that are managed care companies could also seek to provide services directly to their subscribers, rather than by contracting with the Company for such services. 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 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 79.4 percent, 67.8 percent and 58.8 percent of the Company's net revenue in the years ended December 31, 2013, 2014 and 2015, 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.

Table of Contents

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;
- 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

21

Table of Contents

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 this represents a new business for the Company, 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, since this is a new business for the Company, 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

Table of Contents

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);
- performance-based contractual adjustments to net revenue, reflecting utilization results or other performance measures;
- changes in estimates for contractual adjustments under commercial contracts;

Table of Contents

- 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 due to the recent economic downturn. 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 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 Health, Inc.) 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 Health, Inc.) became a party to the $500.0 million Credit Agreement as the borrower and assumed all of the obligations of Magellan Rx Management, Inc. The 2014 Credit Facility is guaranteed by substantially all of the non-regulated

Table of Contents

subsidiaries of the Company and will mature on July 23, 2019, but the Company holds an option to extend the 2014 Credit Facility for an additional one year period. The 2014 Credit Facility contains a number of covenants.

These covenants 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 2014 Credit Facility also requires the Company to comply with specified financial ratios and tests. Failure to do so, unless waived by the lenders under the 2014 Credit Facility, pursuant to its terms, would result in an event of default. The 2014 Credit Facility is guaranteed by most of the Company's subsidiaries and is secured by most of the Company's assets and the Company's subsidiaries' assets.

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, RBM 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. We believe that our state public sector customers will make 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.

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

Table of Contents

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 ("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. Government investigations and allegations have become more frequent concerning possible violations of fraud and abuse and false claims statutes and regulations by healthcare organizations. Violators may be 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. A violation of such laws and regulations may have a material adverse effect on the Company.

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;

Table of Contents

- 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.

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' 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.

Table of Contents

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 may be vulnerable 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 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.

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 to obtain personal information for financial gain, attempting to cause harm to our operations, or intending to obtain competitive information. Our systems are also subject to the attack of viruses, worms, 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. A breach or failure in our operational security systems may adversely impact the Company's financial condition and 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 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 new transparency requirements on PBMs, and the Centers for Medicare and Medicaid Services ("CMS") issued a final rule implementing these requirements in April 2012. 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.

Table of Contents

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, 2015 reflect goodwill of approximately $621.4 million, representing approximately 30.0 percent of total assets. The Company completed its annual impairment analysis of goodwill as of October 1, 2015, noting that no impairment was identified.

At December 31, 2015, identifiable intangible assets (customer lists, contracts and provider networks) totaled approximately $133.4 million. Intangible assets are 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.

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, 2015, the Company had approximately $79.3 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.

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. 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

Table of Contents

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.

Government Investigations The Company may be subjected to additional regulatory requirements and to investigations or regulatory action by governmental agencies, each of which may have a material adverse effect on the Company's business, financial condition and results of operations.

From time to time, the Company 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.

In addition, the Company may become subject to regulatory investigations relating to the Company's business, which 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 the 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.

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 $326.2 million and represented 15.8 percent of the Company's total assets at December 31, 2015.

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 The state of the national economy and adverse changes in economic conditions could adversely affect the Company's business and results of operations.

The state of the economy has negatively affected state budgets and could adversely affect the Company's reimbursement from state Medicaid programs in its Public Sector segment. The state of the economy and 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, the 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.

Table of Contents

Adverse economic conditions in the debt markets may affect the Company's ability to refinance the Company's existing 2014 Credit Facility upon its maturity on July 23, 2019 on acceptable terms, or at all.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

The Company currently leases approximately one million square feet of office space comprising 49 offices in 27 states and the District of Columbia with terms expiring between May 31, 2016 and January 31, 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. In the opinion of management, the Company has recorded reserves that 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.

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

Since January 6, 2004, shares of the Company's Ordinary Common Stock, $0.01 par value per share ("common stock") have traded 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. The following tables set forth the high and low closing bid prices of the Company's common stock as reported by the NASDAQ Stock Market for the years ended December 31, 2014 and 2015, as follows:

	Common Stock Sales Prices	
	High	**Low**
2014		
First Quarter	61.14	58.22
Second Quarter	63.06	54.77
Third Quarter	63.62	54.29
Fourth Quarter	62.38	52.78
2015		
First Quarter	70.82	57.99
Second Quarter	72.12	60.22
Third Quarter	70.22	53.72
Fourth Quarter	63.06	46.17

As of December 31, 2015, there were approximately 270 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.

Table of Contents

Comparison of Cumulative Total Returns

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, 2010, and comparing relative values on December 31, 2011, 2012, 2013, 2014 and 2015. 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.

Comparison of Cumulative Total Return

Comparison of Cumulative Five Year Total Return

	December 31,					
	2010	**2011**	**2012**	**2013**	**2014**	**2015**
Magellan Health, Inc.	$ 100.00	$ 104.63	$ 103.64	$ 126.71	$ 126.97	$ 130.41
S&P 500 Index	100.00	102.11	118.45	156.82	178.29	180.75
S&P 500 Managed Health Care Index(1)	100.00	134.40	142.41	210.57	281.34	342.88

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

The information set forth above under the "Comparison of Cumulative Total Returns" 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

Table of Contents

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 26, 2017. Pursuant to this program, the Company made purchases during the three months ended December 31, 2015 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, 2015	616,075	$ 50.64	616,075	$ 200.0
November 1 - 30, 2015	345,044	53.46	345,044	181.6
December 1 - 31, 2015				181.6
	961,119		961,119	

(1) Excludes broker commissions.

(2) 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.

The Company made no share repurchases from January 1, 2016 through February 24, 2016.

Dividends

The Company did not declare any dividends during either of the years ended December 31, 2014 or 2015 and does not expect to pay a dividend in 2016. The Company is prohibited from paying dividends on its common stock under the terms of the 2014 Credit Facility, except in limited circumstances. The declaration and payment of any dividends in the future by the Company will be subject to the sole discretion of the Company's board of directors and will depend upon many factors, including the Company's financial condition, earnings, covenants associated with the Company's 2014 Credit Facility and any similar future agreement, legal requirements, regulatory constraints and other factors deemed relevant by the Company's board of directors. Moreover, should the Company pay any dividends in the future, there can be no assurance that the Company will continue to pay such dividends.

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, 2011, 2012, 2013, 2014 and 2015.

Selected consolidated financial information for the years ended December 31, 2013, 2014 and 2015 and as of December 31, 2014 and 2015 presented below, have been derived from, and should be read in conjunction with, the audited consolidated financial statements and the notes thereto included elsewhere herein. Selected consolidated financial information for the years ended December 31, 2011 and 2012 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.

Table of Contents

MAGELLAN HEALTH, INC. AND SUBSIDIARIES
(In thousands, except per share amounts)

	Year Ended December 31,				
	2011	2012	2013	2014	2015
Statement of Operations Data:					
Net revenue	$ 2,799,400	$ 3,207,397	$ 3,546,317	$ 3,760,118	$ 4,597,400
Cost of care	1,784,724	2,071,890	2,232,976	2,088,595	2,274,755
Cost of goods sold	232,038	328,414	455,601	732,949	1,321,877
Direct service costs and other operating expenses(1)(2)	529,634	557,512	619,546	723,498	822,392
Depreciation and amortization	58,623	60,488	71,994	91,070	102,844
Interest expense	2,502	2,247	3,000	7,387	6,581
Interest and other income	(2,781)	(2,019)	(1,985)	(1,301)	(2,165)
Income before income taxes	194,660	188,865	165,185	117,920	72,116
Provision for income taxes	65,037	37,838	39,924	43,689	42,409
Net income	129,623	151,027	125,261	74,231	28,707
Less: net income (loss) attributable to non-controlling interest				(5,173)	(2,706)
Net income attributable to Magellan Health, Inc.	$ 129,623	$ 151,027	$ 125,261	$ 79,404	$ 31,413
Net income per common share attributable to Magellan Health, Inc.:					
Basic	$ 4.25	$ 5.51	$ 4.63	$ 2.98	$ 1.26
Diluted	$ 4.17	$ 5.42	$ 4.53	$ 2.90	$ 1.21

	December 31,				
	2011	2012	2013	2014	2015
Balance Sheet Data:					
Current assets	$ 732,709	$ 871,418	$ 989,358	$ 1,140,323	$ 1,097,682
Current liabilities	369,550	393,202	476,267	585,840	724,235
Property and equipment, net	118,022	136,548	172,333	171,916	174,745
Total assets	1,341,167	1,512,133	1,759,218	2,068,943	2,069,060
Total debt and capital lease obligations			26,725	269,841	257,309
Stockholders' equity	845,274	1,017,333	1,156,485	1,133,558	1,066,183

(1) Includes stock compensation expense of $17.4 million, $17.8 million, $21.3 million, $40.6 million and $50.4 million in 2011, 2012, 2013, 2014 and 2015, respectively.

(2) Includes changes in fair value of contingent consideration of $6.2 million and $44.3 million in 2014 and 2015, respectively.

Table of Contents

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 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.

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:

Managed Care and Other Revenue

Managed Care Revenue. Managed care revenue, inclusive of revenue from the Company's risk, EAP and ASO contracts, is recognized over the applicable coverage period on a per member basis for covered members. The Company is paid a per member fee for all enrolled members, and this fee is recorded as revenue in the month in which members are entitled to service. The Company adjusts its revenue for retroactive membership terminations, additions and other changes, when such adjustments are identified, with the exception of retroactivity that can be reasonably estimated. The impact of retroactive rate amendments is generally recorded in the accounting period that terms to the amendment are finalized, and that the amendment is executed. Any fees paid prior to the month of service are recorded as deferred revenue. Managed care revenues approximated $2.7 billion, $2.6 billion and $2.7 billion for the years ended December 31, 2013, 2014 and 2015, respectively.

Rebate Revenue. The Company administers a rebate program 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. Each period, the Company estimates the total

Table of Contents

rebates earned based on actual volumes of pharmaceutical purchases by the Company's clients, as well as historical and/or anticipated sharing percentages. The Company earns fees based upon the volume of rebates generated for its clients. The Company does not record as rebate revenue any rebates that are passed through to its clients. Total rebate revenues for the years ended December 31, 2013, 2014 and 2015 approximated $34.8 million, $43.6 million and $88.7 million, respectively.

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.

PBM and Dispensing Revenue

Pharmacy Benefit Management Revenue. The Company recognizes PBM revenue, which consists of a negotiated prescription price (ingredient cost plus dispensing fee), co-payments collected by the pharmacy and any associated administrative fees, when claims are adjudicated. 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 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. PBM revenues approximated $106.7 million, $575.7 million and $1.2 billion for the years ended December 31, 2013, 2014 and 2015, respectively.

Dispensing Revenue. The Company recognizes dispensing revenue, which includes the co-payments received from members of the health plans the Company serves, when the specialty pharmaceutical drugs are shipped. 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. Revenues from the dispensing of specialty pharmaceutical drugs on behalf of health plans approximated $376.6 million, $216.0 million and $211.6 million for the years ended December 31, 2013, 2014 and 2015, 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 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.

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

Table of Contents

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."

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, 2013, 2014 and 2015 (in thousands):

	2013	2014	2015
Claims payable and IBNR, beginning of period	$ 222,929	$ 242,229	$ 278,803
Cost of care:			
Current year	2,264,276	2,097,395	2,297,255
Prior years(3)	(31,300)	(8,800)	(22,500)
Total cost of care	2,232,976	2,088,595	2,274,755
Claim payments and transfers to other medical liabilities(1):			
Current year	2,053,274	1,845,325	2,077,729
Prior years	160,402	206,696	222,530
Total claim payments and transfers to other medical liabilities	2,213,676	2,052,021	2,300,259
Claims payable and IBNR, end of period	242,229	278,803	253,299
Withhold receivables, end of period(2)	(13,888)	(321)	(2,850)
Medical claims payable, end of period	$ 228,341	$ 278,482	$ 250,449

(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 2013, 2014 and 2015 was $31.3 million, $8.8 million and $22.5 million, respectively.

Development for 2013 was impacted by several factors, including approximately $15.1 million of adjustments resulting from an annual reconciliation process with certain providers, $8.3 million of adjustments related to new contracts in 2012 for which we did not have historical claim payment patterns, and $7.9 million related to faster claims completion rates and lower medical cost trends than originally estimated. The annual reconciliation process for one of our Public Sector contracts, which contract terminated March 31, 2014, identified block payments to providers which exceeded

Table of Contents

the cost of care incurred by such providers; these particular provider contracts required the providers to return such excess block payments to the Company.

Favorable prior year care development for 2014 was related to lower medical trends and faster claims completion than originally assumed in all business segments.

Favorable prior year care development for 2015 was related to faster claims completion than originally assumed, primarily due to new contracts.

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, 2015 unpaid medical claims payable liability assuming hypothetical changes in care trend factors and completion factors:

Care Trend Factor(1)		Completion Factor(2)	
Trend Factor	(Decrease) Increase Medical Claims Payable (in thousands)	Completion Factor	(Decrease) Increase Medical Claims Payable (in thousands)
3%	$ (10,000)	3%	$ (55,500)
2%	(6,500)	2%	(36,500)
1%	(3,500)	1%	(18,000)
1%	3,500	1%	18,000
2%	6,500	2%	36,500
3%	10,000	3%	55,500

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

(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).

(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, 2015; 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. Other medical liabilities also include "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

Table of Contents

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.

Long-lived Assets

Long-lived assets, including property and equipment and definite lived intangible assets to be held and used, are currently reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. 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 for similar assets or the discounted present value of expected future cash flows.

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, with the Company's reporting units with goodwill as of December 31, 2015 comprised of Commercial, Government and Pharmacy Management. Prior to July 1, 2015, the Company's reporting units included Health Plan, Specialty Solutions and Magellan Complete Care. Effective July 1, 2015, the goodwill associated with Health Plan and Specialty Solutions was combined and is now reported as Commercial and Magellan Complete Care is now reported as Government. The change in reporting units was attributable to the Company's segment reorganization and the fact that discrete financial information is now being reviewed at these levels.

The fair value of the Commercial (a component of the Healthcare segment), Government (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.

In connection with the annual impairment testing process, the Company performed a sensitivity analysis for goodwill impairment with respect to each of its reporting units and determined that a

Table of Contents

hypothetical 10% decline in the fair value would not result in an impairment of goodwill for any reporting unit. Therefore, the second step was not necessary.

Goodwill for each of the Company's reporting units with goodwill at December 31, 2014 and 2015 were as follows (in thousands):

	2014	2015
Commercial	$ 233,591	$ 242,255
Government	20,879	18,363
Pharmacy Management	311,636	360,772
Total	$ 566,106	$ 621,390

The changes in the carrying amount of goodwill for the years ended December 31, 2014 and 2015 are reflected in the table below (in thousands):

	2014	2015
Balance as of beginning of period	$ 488,206	$ 566,106
Acquisition of CDMI	69,092	
Acquisition of 4D		49,136
Other acquisitions and measurement period adjustments	8,808	6,148
Balance as of end of period	$ 566,106	$ 621,390

Stock Compensation

At December 31, 2014 and 2015, the Company had equity-based employee incentive plans, which are described more fully in Note 6 "Stockholders' Equity" to the consolidated financial statements set forth elsewhere herein. In addition, the Company issued restricted stock awards associated with the Partners Rx Management, LLC ("Partners Rx") and CDMI, LLC ("CDMI") acquisitions, which are described more fully in Note 6 "Stockholders' Equity" to the consolidated financial statements set forth elsewhere herein. The Company recorded stock compensation expense of $21.3 million, $40.6 million and $50.4 million for the years ended December 31, 2013, 2014 and 2015, respectively. 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 that include performance conditions, stock compensation is recognized using an accelerated method over the vesting period.

The Company estimates the fair value of substantially all stock options using the Black-Scholes-Merton option pricing model that employs certain factors including expected volatility of stock price, expected life of the option, risk-free interest rate and expected dividend yield. For the years ended December 31, 2013, 2014 and 2015, such volatility was based on the historical volatility of the Company's stock price. The expected term of the option is based on historical employee stock option exercise behavior and the vesting terms of the respective option. Risk-free interest rates are based on the U.S. Treasury yield in effect at the time of grant.

The Company recognizes compensation expense for only the portion of options, restricted stock or restricted stock units that are ultimately expected to vest. Therefore, estimated forfeiture rates are derived from historical employee termination behavior. The Company's estimated forfeiture rates, for its various awards, for the years ended December 31, 2013, 2014 and 2015 ranged between zero and 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

Table of Contents

estimated using the most probable outcome of the performance goals, and adjusted as the expected outcome changes.

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.

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 adjusts these accruals, 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.

Results of Operations

The accounting policies of the Company's segments are the same as those described in Note 1 "General." 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 above.

Table of Contents

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, 2013				
Managed care and other revenue	$ 2,900,592	$ 228,705	$ (66,248)	$ 3,063,049
PBM and dispensing revenue		483,268		483,268
Cost of care	(2,239,997)	(59,227)	66,248	(2,232,976)
Cost of goods sold		(455,601)		(455,601)
Direct service costs and other	(352,644)	(128,427)	(138,475)	(619,546)
Stock compensation expense(1)	3,171	1,172	16,909	21,252
Segment profit (loss)	$ 311,122	$ 69,890	$ (121,566)	$ 259,446

	Healthcare	Pharmacy Management	Corporate and Elimination	Consolidated
Year Ended December 31, 2014				
Managed care and other revenue	$ 2,780,905	$ 205,524	$ (18,055)	$ 2,968,374
PBM and dispensing revenue		844,512	(52,768)	791,744
Cost of care	(2,090,352)	(16,298)	18,055	(2,088,595)
Cost of goods sold		(784,758)	51,809	(732,949)
Direct service costs and other	(420,092)	(182,833)	(120,573)	(723,498)
Stock compensation expense(1)	2,899	28,829	8,856	40,584
Changes in fair value of contingent consideration(1)	38	6,134		6,172
Less: non-controlling interest segment profit (loss)(2)	(5,087)			(5,087)
Segment profit (loss)	$ 278,485	$ 101,110	$ (112,676)	$ 266,919

	Healthcare	Pharmacy Management	Corporate and Elimination	Consolidated
Year Ended December 31, 2015				
Managed care and other revenue	$ 2,959,252	$ 238,456	$ (63)	$ 3,197,645
PBM and dispensing revenue		1,510,180	(110,425)	1,399,755
Cost of care	(2,274,755)			(2,274,755)
Cost of goods sold		(1,427,680)	105,803	(1,321,877)
Direct service costs and other	(438,019)	(265,661)	(118,712)	(822,392)
Stock compensation expense(1)	2,556	34,864	12,964	50,384
Changes in fair value of contingent consideration(1)	(1,404)	45,661		44,257
Less: non-controlling interest segment profit (loss)(2)	(2,439)		(195)	(2,634)
Segment profit (loss)	$ 250,069	$ 135,820	$ (110,238)	$ 275,651

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

Table of Contents

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

The following table reconciles Segment Profit to consolidated income before income taxes for the years ended December 31, 2013, 2014 and 2015 (in thousands):

	2013	2014	2015
Segment Profit	$ 259,446	$ 266,919	$ 275,651
Stock compensation expense	(21,252)	(40,584)	(50,384)
Changes in fair value of contingent consideration		(6,172)	(44,257)
Non-controlling interest segment profit (loss)		(5,087)	(2,634)
Depreciation and amortization	(71,994)	(91,070)	(102,844)
Interest expense	(3,000)	(7,387)	(6,581)
Interest and other income	1,985	1,301	2,165
Income before income taxes	$ 165,185	$ 117,920	$ 71,116

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 Health, Inc. ("Adjusted Net Income") and adjusted net income per common share attributable to Magellan Health, Inc. on a diluted basis ("Adjusted EPS"). Adjusted Net Income and Adjusted EPS reflect certain adjustments made for acquisitions 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, as well as amortization 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 we disclose, 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 Adjusted Net Income to net income attributable to Magellan Health, Inc. for the years ended December 31, 2013, 2014, and 2015 (in thousands):

	2013	2014	2015
Adjusted Net Income	$ 126,683	$ 110,555	$ 91,775
Adjusted for acquisitions starting in 2013			
Stock compensation expense relating to acquisitions	(831)	(27,594)	(32,235)
Changes in fair value of contingent consideration		(9,304)	(44,257)
Amortization of acquired intangibles	(1,453)	(13,696)	(21,371)
Tax impact	862	19,443	37,501
Net income attributable to Magellan Health, Inc.	$ 125,261	$ 79,404	$ 31,413

Table of Contents

The following table reconciles Adjusted EPS to net income per common share attributable to Magellan Health, Inc. diluted for the years ended December 31, 2013, 2014, and 2015:

	2013	2014	2015
Adjusted EPS	$ 4.58	$ 4.04	$ 3.55
Adjusted for acquisitions starting in 2013			
Stock compensation expense relating to acquisitions	(0.03)	(1.01)	(1.25)
Changes in fair value of contingent consideration		(0.34)	(1.71)
Amortization of acquired intangibles	(0.05)	(0.50)	(0.83)
Tax impact	0.03	0.71	1.45
Net income per common share attributable to Magellan Health, Inc. Diluted	$ 4.53	$ 2.90	$ 1.21

Year ended December 31, 2015 ("2015") compared to the year ended December 31, 2014 ("2014")

Healthcare

Net Revenue

Net revenue related to Healthcare increased by 6.4 percent or $178.3 million from 2014 to 2015. The increase in revenue is mainly due to increased membership from existing customers of $391.3 million, contracts implemented after (or during) 2014 of $157.0 million, favorable rate changes of $34.2 million, increase in net revenue recorded in relation to the Patient Protection and Affordable Care Act health insurer fee ("HIF fee") of $8.9 million, revenue for HSM acquired on January 31, 2015 of $10.0 million, increase in performance based revenue of $7.1 million, risk share revenue of $4.0 million and other net favorable increases of $3.1 million. These increases were partially offset by terminated contracts of $389.1 million, program changes of $43.2 million, customer settlements in 2014 of $3.8 million and retroactive rate and membership adjustments recorded in 2014 of $1.2 million.

Cost of Care

Cost of care increased by 8.8 percent or $184.4 million from 2014 to 2015. The increase in cost of care is primarily due to increased membership from existing customers of $365.4 million, new contracts implemented after (or during) 2014 of $120.2 million, higher care associated with favorable rate changes of $16.6 million, favorable prior period medical claims development recorded in 2014 of $8.8 million, customer settlements recorded in 2014 of $7.7 million, HSM acquired on January 31, 2015 of $4.4 million, care offset associated with risk share revenue of $2.8 million and unfavorable care trends and other net variances of $44.3 million. These increases were partially offset by terminated contracts of $307.5 million, program change of $35.1 million, favorable prior period medical claims development recorded in 2015 of $22.5 million and favorable 2014 medical claims development recorded after 2014 of $20.7 million. For our commercial contracts, cost of care increased as a percentage of risk revenue (excluding EAP business) from 76.4 percent in 2014 to 82.1 percent in 2015, mainly due to unfavorable care trends and business mix. For our government contracts, cost of care increased as a percentage of risk revenue (excluding EAP business) from 87.7 percent in 2014 to 88.1 percent in 2015, mainly due to business mix.

Direct Service Costs

Direct service costs increased by 4.3 percent or $17.9 million from 2014 to 2015 primarily due to cost to support new business and development for the Magellan Complete Care product, partially offset by terminated contracts. Direct service costs decreased as a percentage of revenue from 15.1 percent in 2014 to 14.8 percent in 2015, mainly due to membership growth and new business.

Table of Contents

Pharmacy Management

Managed Care and Other Revenue

Managed care and other revenue related to Pharmacy Management increased by 16.0 percent or $32.9 million from 2014 to 2015. This increase is primarily due to increased rebate revenue of $33.3 million, revenue of $12.1 million for CDMI which was acquired on April 30, 2014 and new contracts implemented after (or during) 2014 of $7.5 million. These increases were partially offset by terminated contracts of $18.1 million and other net decreases of $1.9 million.

PBM and Dispensing Revenue

PBM and dispensing revenue related to Pharmacy Management increased by 78.8 percent or $665.7 million from 2014 to 2015. This increase is primarily due to revenue for 4D acquired on April 1, 2015 of $368.0 million, new contracts implemented after (or during) 2014 of $136.2 million, an increase in pharmacy employer revenue of $114.3 million, an increase in pharmacy MCO revenue of $83.0 million and net increased dispensing activity from existing customers of $10.6 million. These increases were partially offset by terminated contracts of $43.6 million and other net unfavorable variances of $2.8 million.

Cost of Care

Cost of care decreased by $16.3 million from 2014 to 2015 due to a terminated contract.

Cost of Goods Sold

Cost of goods sold increased by 81.9 percent or $642.9 million from 2014 to 2015. This increase is primarily due to 4D acquired on April 1, 2015 of $356.0 million, new contracts implemented after (or during) 2014 of $132.4 million, an increase in pharmacy employer of $103.2 million, pharmacy MCO of $82.6 million and net increased dispensing activity from existing customers of $11.9 million. These increases were partially offset by terminated contracts of $42.1 million and other net favorable variances of $1.1 million. As a percentage of the portion of net revenue that relates to PBM and dispensing activity, cost of goods sold increased from 92.9 percent in 2014 to 94.5 percent in 2015, mainly due to business mix.

Direct Service Costs

Direct service costs increased by 45.3 percent or $82.8 million from 2014 to 2015. This increase mainly relates to changes in the fair value of contingent consideration related to the CDMI and 4D acquisitions of $39.5 million, in addition to additional cost from the acquisition of 4D and implementation costs and ongoing costs to support new business. As a percentage of revenue, direct service costs decreased from 17.4 percent in 2014 to 15.2 percent in 2015, mainly due to the increase in revenue from business growth and acquisition activity, partially offset by the fair value of contingent consideration.

Corporate and Elimination

Net expenses related to Corporate, which includes eliminations, increased by 1.5 percent or $1.9 million, primarily due to an increase in stock compensation expense, partially offset by lower discretionary benefit costs. As a percentage of revenue, corporate and elimination decreased from 3.2 percent in 2014 to 2.7 percent in 2015, mainly due to the increase in revenue due to acquisitions and new business.

Table of Contents

Depreciation and Amortization

Depreciation and amortization expense increased by 12.9 percent or $11.8 million from 2014 to 2015, primarily due to asset additions after 2014 and acquisition activity.

Interest Expense

Interest expense decreased by $0.8 million from 2014 to 2015, mainly due to contingent consideration expense for CDMI recorded in 2014, partially offset by borrowings under the 2014 Credit Facility in September 2014.

Interest Income

Interest income increased by $0.9 million from 2014 to 2015, primarily due to higher yields and an increase in invested balances.

Income Taxes

The Company's effective income tax rate was 37.0 percent in 2014 and 59.6 percent in 2015. These rates differ from the federal statutory income tax rate primarily due to state income taxes, permanent differences between book and tax income, and changes to recorded tax contingencies and valuation allowances. The Company also accrues interest and penalties related to unrecognized tax benefits in its provision for income taxes. The effective income tax rate for 2014 was lower than 2015 mainly due to lower reversals of tax contingencies in 2015 from the closure of statutes of limitations and a more significant impact in 2015 from the non-deductible HIF fees due to lower overall income.

The statutes of limitations regarding the assessment of federal and most state and local income taxes for 2011 expired during 2015. As a result, $3.1 million of unrecognized tax benefits recorded as of December 31, 2014 were reversed in the current year, of which $2.0 million was reflected as a reduction to income tax expense, $1.0 million as a decrease to deferred tax assets, and the remainder as an increase to additional paid-in capital. Additionally, $0.4 million of accrued interest and $0.7 million of unrecognized state tax benefits were reversed in 2015 and reflected as reductions to income tax expense due to the closing of statutes of limitations on tax assessments and the favorable settlement of state income tax examinations.

The statutes of limitations regarding the assessment of federal and most state and local income taxes for 2010 expired during 2014. As a result, $19.5 million of unrecognized tax benefits recorded as of December 31, 2013 were reversed in 2014, of which $16.0 million was reflected as a reduction to income tax expense, $2.6 million as an increase to additional paid-in capital, and the remainder as a decrease to deferred tax assets. Additionally, $1.4 million of accrued interest was reversed in 2014 and reflected as a reduction to income tax expense due to the closing of statutes of limitations on tax assessments.

2014 compared to the year ended December 31, 2013 ("2013")

Healthcare

Net Revenue

Net revenue related to Healthcare decreased by 4.1 percent or $119.7 million from 2013 to 2014. The decrease in revenue is mainly due to terminated contracts of $835.8 million, program changes of $16.5 million, customer settlements in 2013 of $5.6 million and retroactive rate and membership adjustments recorded in 2013 of $2.9 million. These decreases were partially offset by revenue related to new contracts implemented after (or during) 2013 of $384.3 million, increased membership from existing customers of $220.4 million, cost-plus contracts with higher care in 2014 of $37.7 million,

Table of Contents

revenue recorded for HIF fees of $36.5 million, favorable rate changes of $36.4 million, performance based revenue of $8.0 million, customer settlements in 2014 of $3.9 million, the revenue impact of favorable medical claims development for 2012 recorded in 2013 of $2.0 million, retroactive rate and membership adjustments recorded in 2014 of $1.2 million and other net favorable increases of $10.7 million.

Cost of Care

Cost of care decreased by 6.7 percent or $149.6 million from 2013 to 2014. The decrease in cost of care is primarily due to terminated contracts of $716.6 million, program changes of $12.4 million, favorable prior period medical claims development recorded in 2014 of $8.8 million and customer settlements recorded in 2014 of $7.7 million. These decreases were partially offset by new contracts of $297.3 million, increased membership from existing customers of $204.2 million, care trends and other net variances of $40.0 million, favorable prior period medical claims development recorded in 2013 of $31.3 million and care associated with rate changes for contracts with minimum care requirements of $23.1 million. For our commercial contracts, cost of care decreased as a percentage of risk revenue (excluding EAP business) from 77.1 percent in 2013 to 76.4 percent in 2014, mainly due to favorable rate changes and business mix. For our government contracts, cost of care decreased as a percentage of risk revenue (excluding EAP business) from 88.3 percent in 2013 to 87.7 percent in 2014, mainly due to business mix.

Direct Service Costs

Direct service costs increased by 19.1 percent or $67.5 million from 2013 to 2014 primarily due to expense incurred for HIF fees of $21.4 million and costs to support new business and development for the Magellan Complete Care product, which increases were partially offset by severance and restructuring costs of terminated contracts recorded in 2013 of $11.5 million. Direct service costs increased as a percentage of net revenue from 12.2 percent in 2013 to 15.1 percent in 2014, mainly due cost to support new business, the development cost for the MCC product and business mix.

Pharmacy Management

Managed Care and Other Revenue

Managed care and other revenue related to Pharmacy Management decreased by 10.1 percent or $23.2 million from 2013 to 2014. This decrease is primarily due to terminated contracts of $63.7 million and decreased rebate revenue due to change in terms of $5.4 million. These decreases were partially offset by revenue of $31.4 for CDMI which was acquired on April 30, 2014, new contracts implemented after (or during) 2013 of $7.5 million, increased government pharmacy revenue of $4.3 million, increased medical pharmacy revenue of $1.8 million and other net favorable variances of $0.9 million.

PBM and Dispensing Revenue

PBM and dispensing revenue related to Pharmacy Management increased by 74.8 percent or $361.2 million from 2013 to 2014. This increase is primarily due to new contracts of $252.7 million, higher revenue of $245.3 million for Partners Rx which was acquired on October 1, 2013, an increase in pharmacy employer revenue of $19.8 million and other net increases of $1.6 million. These increases were partially offset by terminated distribution and rebate contracts of $151.7 million and net decreased dispensing activity from existing customers of $6.5 million.

Cost of Care

Cost of care decreased by 72.5 percent or $42.9 million from 2013 to 2014. This decrease is primarily due to terminated contracts. Cost of care as a percentage of risk revenue was 89.5 percent in 2013 and 90.1 percent in 2014.

Cost of Goods Sold

Cost of goods sold increased by 72.2 percent or $329.2 million from 2013 to 2014. This increase is primarily due to new contracts implemented after (or during) 2013 of $246.1 million, higher cost of goods sold for Partners Rx of $220.4 million, pharmacy employer business of $15.3 million and other net increases of $0.9 million. These increases were partially offset by terminated contracts of $143.2 million and decreased dispensing activity of $10.3 million. As a percentage of PBM and dispensing revenue, cost of goods sold decreased from 94.3 percent in 2013 to 92.9 percent in 2014, mainly due to business mix.

Direct Service Costs

Direct service costs increased by 42.4 percent or $54.4 million from 2013 to 2014. This increase mainly relates to costs for Partners Rx, changes in the present value of contingent consideration, implementation costs, and ongoing costs to support new business. As a percentage of net revenue, direct service costs decreased from 18.0 percent in 2013 to 17.4 percent in 2014, mainly due to business mix.

Corporate and Other

Other Operating Expenses

Other operating expenses related to the Corporate and Other segment decreased by 12.9 percent or $17.9 million from 2013 to 2014. The decrease results primarily from severance and other one time items incurred in 2013 of $12.4 million and a decrease in stock compensation expense of $8.1 million. These decreases were partially offset by other net unfavorable variances of $2.6 million. As a percentage of total net revenue, other operating expenses decreased from 3.9 percent for 2013 to 3.2 percent for 2014, primarily due to business mix.

Depreciation and Amortization

Depreciation and amortization expense increased by 26.5 percent or $19.1 million from 2013 to 2014, primarily due to asset additions after 2013 and acquisition activity.

Interest Expense

Interest expense increased by $4.4 million from 2013 to 2014, primarily due to capital lease additions after 2013, current year borrowings under the 2014 Credit Facility, and due to changes in the fair value of contingent consideration of $3.1 million recorded to interest expense in 2014.

Interest Income

Interest income decreased by 34.5 percent or $0.7 million from 2013 to 2014 primarily due to lower cash balances as a result of acquisition activity after (or during) 2013.

Income Taxes

The Company's effective income tax rate was 24.2 percent in 2013 and 37.0 percent in 2014. These rates differ from the federal statutory income tax rate primarily due to state income taxes, permanent

Table of Contents

differences between book and tax income, and changes to recorded tax contingencies and valuation allowances. The Company also accrues interest and penalties related to unrecognized tax benefits in its provision for income taxes. The effective income tax rate for 2013 was lower than 2014 mainly due to the non-deductible HIF fees in 2014, lower reversals of tax contingencies in 2014 from the closure of statutes of limitations, and increased valuation allowances in 2014 for certain deferred tax assets.

The statutes of limitations regarding the assessment of federal and most state and local income taxes for 2010 expired during 2014. As a result, $19.5 million of unrecognized tax benefits recorded as of December 31, 2013 were reversed in 2014, of which $16.0 million was reflected as a reduction to income tax expense, $2.6 million as an increase to additional paid-in capital, and the remainder as a decrease to deferred tax assets. Additionally, $1.4 million of accrued interest was reversed in 2014 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 2009 expired during 2013. As a result, $28.6 million of unrecognized tax benefits recorded as of December 31, 2012 were reversed in 2013, of which $23.2 million was reflected as a reduction to income tax expense, $3.9 million as an increase to additional paid-in capital, and the remainder as a decrease to deferred tax assets. Additionally, $2.1 million of accrued interest was reversed in 2013 and reflected as a reduction to income tax expense due to the closing of statutes of limitations on tax assessments.

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 2 "Forward-Looking Statements" 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; (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.

Care Trends. The Company expects that same-store normalized cost of care trend for the 12 month forward outlook to be 3 to 7 percent for commercial products and 0 to 2 percent for government business.

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 Company's 2014 Credit Facility. Based on the amount of cash equivalents and investments and the borrowing levels under the 2014 Credit Facility as of December 31, 2015, 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.

Table of Contents

Historical Liquidity and Capital Resources

2015 compared to 2014

Operating Activities. The Company reported net cash provided by operating activities of $211.0 million and $239.2 million for 2014 and 2015, respectively. The $28.2 million increase in operating cash flows from 2014 to 2015 is attributable to a net shift of restricted funds between cash and investments that results in an operating cash flow change that is directly offset by an investing cash flow change and an increase in Segment Profit, partially offset by net unfavorable working capital changes and an increase in tax payments between years.

Restricted cash of $26.0 million and $105.3 million in 2014 and 2015, respectively, were shifted to restricted investments that increased operating cash flows. The net impact of the shift in restricted funds between periods is an increase in operating cash flows of $79.3 million. Segment Profit for 2015 increased $8.7 million from 2014.

The net unfavorable impact of working capital changes between years totaled $53.6 million. For 2014, operating cash flows were impacted by net unfavorable working capital and other changes of $24.2 million, largely attributable to the net impact of HIF fee activity and the run-out of medical claims payable associated with terminated Commercial contracts, partially offset by a net decrease in restricted cash requirements associated with the Company's regulated entities. For 2015, operating cash flows were impacted by net unfavorable working capital changes of $77.8 million, which were largely attributable to an increase in accounts receivable partially offset by HIF fee activity. Tax payments for 2015 totaled $63.9 million, which represents an increase of $6.2 million from 2014.

During 2015, the Company's restricted cash decreased $81.7 million. The change in restricted cash is attributable to the net shift of restricted cash of $105.3 million to restricted investments, net increase in restricted cash of $22.1 million associated with the Company's regulated entities, and other net increases of $1.5 million. The net change in restricted cash for the Company's regulated entities is attributable to a net increase in restricted cash requirements of $5.3 million that resulted in an operating cash flow use and a net increase in restricted cash of $16.8 million that is offset by changes in other assets and liabilities, primarily accounts receivable, accrued liabilities and accrued taxes, thus having no impact on operating cash flows.

Investing Activities. The Company utilized $62.3 million and $71.6 million during 2014 and 2015, respectively, for capital expenditures. The additions related to hard assets (equipment, furniture, and leaseholds) and capitalized software for 2014 were $16.9 million and $45.4 million, respectively, as compared to additions for 2015 related to hard assets and capitalized software of $27.3 million and $44.3 million, respectively.

The Company used net cash of $64.5 million and $65.8 million during 2014 and 2015 for the net purchase of "available for sale" securities. In 2014, the Company used net cash of $121.1 million and $7.9 million for the acquisitions of CDMI and Cobalt Therapeutics, LLC ("Cobalt"), respectively, with the Company using net cash of $42.2 million and $13.6 million for the acquisitions of 4D and HSM, respectively, in 2015. In addition, the Company received cash of $0.7 million in 2014 related to the settlement of working capital associated with the Partners Rx acquisition.

Financing Activities. During 2014, the Company received $250.0 million from the issuance of debt and $53.0 million from the exercise of stock options. In addition, the Company paid $197.5 million for the repurchase of treasury stock under the Company's share repurchase program, $4.9 million on capital lease obligations and $3.1 million on debt obligations, and had other net unfavorable items of $1.2 million.

During 2015, the Company paid $206.0 million for the repurchase of treasury stock under the Company's share repurchase program, $12.5 million on debt obligations, and $4.5 million on capital

Table of Contents

lease obligations. The Company made contingent consideration payments totaling $29.3 million of which $20.8 million was related to financing activities. In addition, the Company received $53.5 million from the exercise of stock options and had other net favorable items of $4.4 million.

2014 compared to 2013

Operating Activities. The Company reported net cash provided by operating activities of $183.2 million and $211.0 million for 2013 and 2014, respectively. The $27.8 million increase in operating cash flows from 2013 to 2014 is attributable to an increase in Segment Profit, lower tax payments and net favorable working capital changes between periods, partially offset by the impact of the net shift of restricted funds between cash and investments that results in an operating cash flow change that is directly offset by an investing cash flow change.

Segment Profit for 2014 increased $7.5 million from 2013. Tax payments for 2014 totaled $57.7 million, which represents a decrease of $7.8 million from 2013. The net favorable impact of working capital changes between periods totaled $15.7 million. Operating cash flows for 2013 were impacted by net unfavorable working capital and other changes totaling $39.9 million, which were largely attributable to a net increase in restricted cash requirements associated with the Company's regulated entities. For 2014, operating cash flows were impacted by net unfavorable working capital and other changes of $24.2 million, largely attributable to the net impact of HIF fee activity and the run-out of medical claims payable associated with terminated Commercial contracts, partially offset by a net decrease in restricted cash requirements associated with the Company's regulated entities. In 2013, the Company was required to restrict additional funds of $45.9 million, as compared to the release of restricted funds of $22.1 million in 2014. Revenues of $36.5 million associated with the reimbursement of the economic impact of the HIF fee from its customers were recorded in 2014, with the majority of these revenues uncollected as of year-end.

Restricted cash of $29.2 million and $26.0 million in 2013 and 2014, respectively, were shifted to restricted investments that increased operating cash flows. The net impact of the shift in restricted funds between periods is a decrease in operating cash flows of $3.2 million.

During 2014, the Company's restricted cash decreased $21.4 million. The change in restricted cash is attributable to the net shift of restricted cash of $26.0 million to restricted investments and other net decreases of $2.4 million, partially offset by the net increase in restricted cash of $7.0 million associated with the Company's regulated entities. The net change in restricted cash for the Company's regulated entities is attributable to a net increase in restricted cash of $29.1 million that is offset by changes in other assets and liabilities, primarily accounts receivable, accrued liabilities, medical claims payable and other medical liabilities, thus having no impact on operating cash flows, partially offset by a net decrease in restricted cash requirements of $22.1 million that resulted in an operating cash flow source.

Investing Activities. The Company utilized $64.5 million and $62.3 million during 2013 and 2014, respectively, for capital expenditures. The additions related to hard assets (equipment, furniture and leaseholds) and capitalized software for 2013 were $24.4 million and $40.1 million, respectively, as compared to additions for 2014 related to hard assets and capitalized software of $16.9 million and $45.4 million, respectively. During 2013, the Company had non-cash capital lease additions of $26.9 million and $2.8 million associated with properties and software, respectively, as compared to non-cash capital lease additions for 2014 related to properties and software of $0.1 million and $2.7 million, respectively.

The Company received net cash of $16.2 million from the net maturity of "available for sale" securities during 2013, with the Company using net cash of $64.5 million during 2014 for the net purchase of "available for sale" securities. In 2013, the Company used net cash of $88.5 million and $19.1 million for the acquisitions of Partners Rx and AlphaCare, respectively, with the Company using net cash of $121.1 million and $7.9 million for the acquisitions of CDMI and Cobalt, respectively, in

2014. In addition, the Company received cash of $0.7 million in 2014 related to the settlement of working capital associated with the Partners Rx acquisition.

Financing Activities. During 2013, the Company paid $60.7 million for the repurchase of treasury stock under the Company's share repurchase program and $3.0 million on capital lease obligations. In addition, the Company received $47.5 million from the exercise of stock options and had other net favorable items of $2.6 million.

During 2014, the Company received $250.0 million from the issuance of debt and $53.0 million from the exercise of stock options. In addition, the Company paid $197.5 million for the repurchase of treasury stock under the Company's share repurchase program, $4.9 million on capital lease obligations and $3.1 million on debt obligations, and had other net unfavorable items of $1.2 million.

Outlook Liquidity and Capital Resources

Liquidity

During 2016, the Company expects to fund its estimated capital expenditures of $63.0 to $73.0 million and contingent consideration of $91.1 million with cash from operations. The Company may draw on the 2014 Credit Facility to fund a portion of cash required for its acquisition activities, or to the extent that the anticipated timing of receivables, payables or share repurchases changes during the year. The Company also 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 situation in 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 that the Company will not experience any such losses in the future.

Contractual Obligations and Commitments

The following table sets forth the future financial commitments of the Company as of December 31, 2015 (in thousands):

	Payments due by period				
Contractual Obligations	**Total**	**Less than 1 year**	**1 - 3 years**	**3 - 5 years**	**More than 5 years**
Term loan	$ 234,375	$ 15,625	$ 50,000	$ 168,750	$
Operating leases(1)	90,733	18,385	30,987	20,892	20,469
Letters of credit(2)	33,366				
Capital lease obligations(3)	29,971	303	8,355	6,399	14,914
Purchase commitments(4)	3,112	3,112			
Income tax contingencies(5)	12,413	138			
Contingent consideration(6)	91,080	91,080			
	$ 495,050	$ 128,643	$ 89,342	$ 196,041	$ 35,383

(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 obligations include imputed interest of $5.6 million and are net of leasehold improvement allowances.

Table of Contents

(4) Purchase commitments include open purchase orders as of December 31, 2015 relating to ongoing capital expenditure and operational activities.

(5) Other than the estimated amount to be paid during 2016, 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.

(6) As of December 31, 2015, in addition to the $91.1 million of undiscounted contingent consideration disclosed in the table above, the Company has an additional $1.7 million of undiscounted contingent consideration that has been excluded as uncertainty still exists about their amounts. For additional detail see Note 2 "Summary of Significant Accounting Policies Fair Value Measurements" 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, 2015, the Company has no material off-balance sheet arrangements.

2014 Credit Facility

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 Health, Inc.) 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"). At such point, the previous credit facility was terminated. 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 Health, Inc.) became a party to the $500.0 million Credit Agreement as the borrower and assumed all of the obligations of Magellan Rx Management, Inc. The 2014 Credit Facility is guaranteed by substantially all of the non-regulated subsidiaries of the Company and will mature on July 23, 2019, but the Company holds an option to extend the 2014 Credit Facility for an additional one year period. For more information on the Company's credit facility see Note 5 "Long-Term Debt and Capital Lease Obligations" to the consolidated financial statements set forth elsewhere herein.

Table of Contents

Restrictive Covenants in Debt Agreements

The 2014 Credit Facility 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 2014 Credit Facility also requires the Company to comply with specified financial ratios and tests. Failure to do so, unless waived by the lenders under the 2014 Credit Facility, pursuant to its terms, would result in an event of default under the 2014 Credit Facility. As of December 31, 2015, the Company was in compliance with all covenants, including financial covenants, under the 2014 Credit Facility.

Item 7A. Quantitative and Qualitative Disclosures about Market Risk

Changes in interest rates affect interest income earned on the Company's cash equivalents and restricted cash and investments, as well as interest expense on variable interest rate borrowings under the 2014 Credit Facility. Based on the Company's investment balances, and the borrowing levels under the 2014 Credit Facility as of December 31, 2015, 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.

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, 2015. Based on their evaluation, management has concluded that the Company's disclosure controls and procedures were effective as of December 31, 2015.

CHANGES IN INTERNAL CONTROL OVER FINANCIAL REPORTING

In the fourth quarter ended December 31, 2015, 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.

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, 2015. 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)."

Management's assessment of the effectiveness of internal control over financial reporting excludes the evaluation of the internal controls over reporting of 4D, which was acquired on April 1, 2015. These operations represent 4.7 percent and 5.5 percent of total and net assets of the Company as of December 31, 2015, and 8.0 percent and 2.5 percent of revenues and Segment Profit, respectively, of the Company for the year then ended.

Based on this assessment, which excluded an assessment of internal control of the acquired operations of 4D, management has concluded that, as of December 31, 2015, 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 29, 2016 appears on page 59 of this Form 10-K.

Table of Contents

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders of Magellan Health, Inc.

We have audited Magellan Health, Inc. and subsidiaries' internal control over financial reporting as of December 31, 2015, 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). Magellan Health, Inc. and subsidiaries' 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 conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). 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.

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.

As indicated in the accompanying Management's Report on Internal Control over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of 4D Pharmacy Management Systems, Inc., which is included in the 2015 consolidated financial statements of Magellan Health, Inc. and subsidiaries and constituted 4.7% of total assets and 5.5% of net assets as of December 31, 2015 as well as 8.0% of revenues and 2.5% of segment profit for the year then ended. Our audit of internal control over financial reporting of Magellan Health, Inc. and subsidiaries also did not include an evaluation of the internal control over financial reporting of 4D Pharmacy Management Systems, Inc.

In our opinion, Magellan Health, Inc. and subsidiaries maintained, in all material respects, effective internal control over financial reporting as of December 31, 2015, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Magellan Health, Inc. and subsidiaries as of December 31, 2014 and 2015, and 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, 2015 and our report dated February 29, 2016 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Baltimore, Maryland
February 29, 2016

Table of Contents

Item 9B. Other Information

Michael Ressner, a director whose current three year term expires at the 2016 annual meeting of shareholders of the Company, will not be running for re-election at the 2016 annual meeting of shareholders. Mr. Ressner has served on the board since 2004. Also on February 25, 2016, the board approved a reduction in the size of the board from nine to eight members and thus does not currently plan to fill the position vacated by Mr. Ressner's departure.

On February 2, 2016, the board also approved the cash out of certain stock options to purchase 5,856 shares each at an exercise price of $40.21 previously issued in May 2006 to William McBride, Michael Diament and Michael Ressner, due to the upcoming expiration of the ten year term of such stock options on May 15, 2016. The cash amount to be paid to each such director will be equal to the difference between the exercise price of $40.21 and the closing price of a share of the Company's common stock on NASDAQ on May 15, 2016 multiplied by 5,856.

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, 2015, except for the following information required by Item 12 of this Part III.

Securities Authorized for Issuance under Equity Compensation Plans

The following table sets forth certain information as of December 31, 2015 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	2,939,840	$ 55.13	913,252(1)
Equity compensation plans not approved by security holders			
Total	2,939,840	$ 55.13	913,252(1)

(1) Consists of shares remaining available for issuance as of December 31, 2015 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-50 of this Report on Form 10-K.

2. Financial Statement Schedule

Information with respect to this item is contained on page S-1 of this Report on Form 10-K.

Table of Contents

3. Exhibits

Exhibit No.	Description of Exhibit
2.1	Share Purchase Agreement between Magellan Health Services, Inc. and California Physicians' Service D/B/A Blue Shield of California, dated January 28, 2011, which was filed as Exhibit 2.3 to the Company's Annual Report on Form 10-K for the year ended December 31, 2010, which was filed on February 25, 2011 and is incorporated herein by reference.
2.2	Purchase Agreement, dated as of March 31, 2014, among Magellan Health Services, Inc., CDMI, LLC, and each Seller's party thereto, which was filed as Exhibit 2.1 to the Company's current report on Form 8-K, which was filed on April 1, 2014 and is incorporated herein by reference.
2.3	Amendment No. 1 to Purchase Agreement, dated as of April 30, 2014, among Magellan Health Services, Inc., CDMI, LLC and each of the Sellers' party thereto, which was filed as Exhibit 2.2 to the Company's current report on Form 8-K, which was filed on April 30, 2014 and is incorporated herein by reference.
3.1	Bylaws of the Company, which were filed as Exhibit 3.1 to the Company's Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2008, which was filed on May 2, 2008, and is incorporated herein by reference.
3.2	Amended and Restated Certificate of Incorporation of the Company, which was filed as Exhibit 3.2 to the Company's Annual Report on Form 10-K for the period ended December 31, 2004, which was filed on March 30, 2004, and is incorporated herein by reference.
3.3	Certificate of Ownership and Merger dated June 4, 2014, which was filed as Exhibit 3.1 to the Company's current report on Form 8-K, which was filed on June 4, 2014 and is incorporated herein by reference.
3.4	Bylaws of the Company as amended and restated on June 4, 2014, which was filed as Exhibit 3.2 to the Company's current report on Form 8-K, which was filed on June 4, 2014 and is incorporated herein by reference.
4.1	Credit Agreement, dated December 9, 2011, among the Company, various lenders listed therein and Citibank, N.A., as administrative agent, which was filed as Exhibit 4.1 to the Company's current report on Form 8-K, which was filed on December 13, 2011 and is incorporated herein by reference.
4.2	$500,000,000 Credit Agreement, dated as of July 23, 2014, among Magellan Rx Management, Inc., as borrower, Magellan Health, Inc., various lenders and Citibank, N.A., as administrative agent, which was filed as Exhibit 4.1 to the Company's quarterly report on Form 10-Q, which was filed on July 25, 2014 and is incorporated herein by reference.
#4.3	Consent and Amendment No. 1 to Credit Agreement, dated December 2, 2015, among Magellan Rx Management, Inc., as borrower, Magellan Health, Inc. various lenders and Citibank N.A., as administrative agent.
*10.1	Magellan Health Services, Inc. 2003 Management Incentive Plan, effective as of January 5, 2004, which was filed as Exhibit 2.14 to the Company's current report on Form 8-K, which was filed on January 6, 2004, and is incorporated herein by reference.

Table of Contents

Exhibit No.	Description of Exhibit
*10.2	Magellan Health Services, Inc. 2005 Director Stock Compensation Plan, effective as of March 3, 2005, which was filed as Appendix B to the Company's definitive proxy statement, filed on April 18, 2005, and is incorporated herein by reference.
*10.3	Form of Stock Option Agreement, relating to options granted under the Company's 2003 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 17, 2005, and is incorporated herein by reference.
*10.4	Form of First Amendment to Stock Option Agreement, relating to options granted under the Company's 2003 Management Incentive Plan, which was filed as Exhibit 10.1 to the Company's current report on Form 8-K, which was filed on January 9, 2006, and is incorporated herein by reference.
*10.5	Form of Notice of March 2005 Stock Option Grant, relating to options granted under the Company's 2003 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 17, 2005, and is incorporated herein by reference.
*10.6	Form of Restricted Stock Agreement, relating to restricted shares granted under the Company's 2003 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 17, 2005, and is incorporated herein by reference.
*10.7	Form of Notice of March 2005 Restricted Stock Award, relating to restricted shares granted under the Company's 2003 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 17, 2005, and is incorporated herein by reference.
*10.8	First form of Notice of Amendment of Stock Option Grant, relating to options granted under the Company's 2003 Management Incentive Plan and dated as of January 3, 2006, between the Company and Steven J. Shulman, Chief Executive Officer of the Company, Rene Lerer, Chief Operating Officer of the Company, and Mark S. Demilio, Chief Financial Officer of the Company, which was filed as Exhibit 10.2 to the Company's current report on Form 8-K, which was filed on January 9, 2006, and is incorporated herein by reference.
*10.9	Second form of Notice of Stock Option Grant, relating to options granted under the Company's 2003 Management Incentive Plan and dated as of January 5, 2004, between the Company and Steven J. Shulman, Chief Executive Officer of the Company, Rene Lerer, Chief Operating Officer of the Company, and Mark S. Demilio, Chief Financial Officer of the Company, which was filed as Exhibit 10.6 to the Company's current report on Form 8-K, which was filed on March 17, 2005, and is incorporated herein by reference.
*10.10	Second form of Notice of Amendment of Stock Option Grant, relating to options granted under the Company's 2003 Management Incentive Plan and dated as of January 3, 2006, between the Company and Steven J. Shulman, Chief Executive Officer of the Company, Rene Lerer, Chief Operating Officer of the Company, and Mark S. Demilio, Chief Financial Officer of the Company, which was filed as Exhibit 10.3 to the Company's current report on Form 8-K, which was filed on January 9, 2006, and is incorporated herein by reference.

Table of Contents

Exhibit No.	Description of Exhibit
*10.11	Third form of Notice of Stock Option Grant, relating to options granted under the Company's 2003 Management Incentive Plan and dated as of January 5, 2004, between the Company and Steven J. Shulman, Chief Executive Officer of the Company, Rene Lerer, Chief Operating Officer of the Company, and Mark S. Demilio, Chief Financial Officer of the Company, which was filed as Exhibit 10.7 to the Company's current report on Form 8-K, which was filed on March 17, 2005, and is incorporated herein by reference.
*10.12	Third form of Notice of Amendment of Stock Option Grant, relating to options granted under the Company's 2003 Management Incentive Plan and dated as of January 3, 2006, between the Company and Steven J. Shulman, Chief Executive Officer of the Company, Rene Lerer, Chief Operating Officer of the Company, and Mark S. Demilio, Chief Financial Officer of the Company, which was filed as Exhibit 10.4 to the Company's current report on Form 8-K, which was filed on January 9, 2006, and is incorporated herein by reference.
*10.13	Form of Notice of Restricted Stock Award, relating to restricted shares granted under the Company's 2003 Management Incentive Plan and dated as of January 5, 2004, between the Company and Steven J. Shulman, Chief Executive Officer of the Company, Rene Lerer, Chief Operating Officer of the Company and Mark S. Demilio, Chief Financial Officer of the Company, which was filed as Exhibit 10.8 to the Company's current report on Form 8-K, which was filed on March 17, 2005, and is incorporated herein by reference.
*10.14	Notice of Restricted Stock Award, relating to restricted shares granted under the Company's 2003 Management Incentive Plan and dated as of January 5, 2004, between the Company and Steven J. Shulman, Chief Executive Officer of the Company, which was filed as Exhibit 10.9 to the Company's current report on Form 8-K, which was filed on March 17, 2005, and is incorporated herein by reference.
*10.15	Supplemental Accumulation Plan, adopted in 2002, which was filed as Exhibit 10.10 to the Company's current report on Form 8-K, which was filed on March 17, 2005, and is incorporated herein by reference.
*10.16	Form of Stock Option Agreement, relating to the 2006 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 22, 2006, and is incorporated herein by reference.
*10.17	Form of Notice of Stock Option Grant, pursuant to the 2006 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 22, 2006, and is incorporated herein by reference.
*10.18	Form of Restricted Stock Unit Agreement, pursuant to the 2006 Management Incentive Plan, which was filed as Exhibit 10.3 to the Company's current report on Form 8-K, which was filed on May 22, 2006, and is incorporated herein by reference.
*10.19	Form of Notice of Restricted Stock Unit Award, pursuant to the 2006 Management Incentive Plan, which was filed as Exhibit 10.4 to the Company's current report on Form 8-K, which was filed on May 22, 2006, and is incorporated herein by reference.
*10.20	Form of Restricted Stock and Stock Option Award Agreement, pursuant to the 2006 Director Equity Compensation Plan, which was filed as Exhibit 10.5 to the Company's current report on Form 8-K, which was filed on May 22, 2006, and is incorporated herein by reference.

Table of Contents

Exhibit No.	Description of Exhibit
*10.21	Magellan Health Services, Inc. 2006 Management Incentive Plan, effective as of May 16, 2006, which was filed as Exhibit 10.1 to the Company's Quarterly report on Form 10-Q for the quarterly period ended June 30, 2006, which was filed on July 28, 2006, and is incorporated herein by reference.
*10.22	Magellan Health Services, Inc. 2006 Director Equity Compensation Plan, effective as of May 16, 2006, which was filed as Exhibit 10.2 to the Company's Quarterly report on Form 10-Q for the quarterly period ended June 30, 2006, which was filed on July 28, 2006, and is incorporated herein by reference.
*10.23	Magellan Health Services, Inc. 2006 Employee Stock Purchase Plan, effective as of May 16, 2006 which was filed as Exhibit 10.3 to the Company's Quarterly report on Form 10-Q for the quarterly period ended June 30, 2006, which was filed on July 28, 2006, and is incorporated herein by reference.
*10.24	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.
*10.25	Amendment to Employment Agreement, dated July 28, 2006, between the Company and Jeffrey N. West, Senior Vice President and Controller of the Company, which was filed as Exhibit 10.2 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.
*10.26	Amendment to Agreements and Documents Governing Restricted Stock Units, dated December 1, 2008, between the Company and Rene Lerer, Chief Executive Officer which was filed as Exhibit 10.66 to the Company's Annual Report on Form 10-K, which was filed on February 29, 2008 and is incorporated herein by reference.
*10.27	Employment Agreement dated February 19, 2008 between the Company and Rene Lerer, M.D., which was filed as Exhibit 10.1 to the Company's current report on Form 8-K, which was filed on February 25, 2008 and is incorporated herein by reference.
*10.28	Employment Agreement, dated February 25, 2008, between the Company and Tina Blasi, which was filed as Exhibit 10.46 to the Company's Annual Report on Form 10-K, which was filed on February 29, 2008 and is incorporated herein by reference.
*10.29	Amendment to Employment Agreement, dated February 25, 2008, between the Company and Tina Blasi, which was filed as Exhibit 10.47 to the Company's Annual Report on Form 10-K, which was filed on February 29, 2008 and is incorporated herein by reference.
*10.30	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.
*10.31	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.

Table of Contents

Exhibit No.	Description of Exhibit
*10.32	Form of Restricted Stock Unit Agreement, relating to restricted stock units granted under the Company's 2008 Management Incentive Plan, which was filed as Exhibit 10.3 to the Company's current report on Form 8-K, which was filed on May 27, 2008 and is incorporated herein by reference.
*10.33	Form of Notice of Restricted Stock Unit Award, relating to restricted stock units granted under the Company's 2008 Management Incentive Plan, which was filed as Exhibit 10.4 to the Company's current report on Form 8-K, which was filed on May 27, 2008 and is incorporated herein by reference.
*10.34	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.
*10.35	Magellan Health Services, Inc. 2008 Management Incentive Plan, effective as of February 27, 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.
*10.36	Amendment to Employment Agreement, dated December 1, 2008, between the Company and Jeffrey West, Senior Vice President and Controller which was filed as Exhibit 10.56 to the Company's Annual Report on Form 10-K, which was filed on February 29, 2008 and is incorporated herein by reference.
*10.37	Amendment to Employment Agreement, dated December 1, 2008, between the Company and Tina Blasi, Chief Executive Officer of National Imaging Associates, Inc. which was filed as Exhibit 10.57 to the Company's Annual Report on Form 10-K, which was filed on February 29, 2008 and is incorporated herein by reference.
*10.38	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 29, 2008 and is incorporated herein by reference.
*10.39	Amendment to Agreements and Documents Governing Restricted Stock Units, dated December 1, 2008, between the Company and Caskie Lewis-Clapper, Chief Human Resources Officer which was filed as Exhibit 10.61 to the Company's Annual Report on Form 10-K, which was filed on February 29, 2008 and is incorporated herein by reference.
*10.40	Amendment to Agreements and Documents Governing Restricted Stock Units, dated December 1, 2008, between the Company and Tina Blasi, Chief Executive Officer of National Imaging Associates, Inc. which was filed as Exhibit 10.62 to the Company's Annual Report on Form 10-K, which was filed on February 29, 2008 and is incorporated herein by reference.
*10.41	Amendment to Agreements and Documents Governing Restricted Stock Units, dated December 1, 2008, between the Company and Jeffrey West, Senior Vice President and Controller which was filed as Exhibit 10.63 to the Company's Annual Report on Form 10-K, which was filed on February 29, 2008 and is incorporated herein by reference.
*10.42	Amendment to Agreements and Documents Governing Restricted Stock Units, dated December 1, 2008, between the Company and Daniel N. Gregoire, Executive Vice President, General Counsel and Secretary which was filed as Exhibit 10.64 to the Company's Annual Report on Form 10-K, which was filed on February 29, 2008 and is incorporated herein by reference.

Table of Contents

Exhibit No.	Description of Exhibit
*10.43	Amendment to Employment Agreement, as amended and restated December 16, 2008, between the Company and Rene Lerer, M.D, Chief Executive Officer which was filed as Exhibit 10.65 to the Company's Annual Report on Form 10-K, which was filed on February 29, 2008 and is incorporated herein by reference.
*10.44	Amendment to Agreements and Documents Governing Restricted Stock Units, dated December 1, 2008, between the Company and Rene Lerer, Chief Executive Officer which was filed as Exhibit 10.66 to the Company's Annual Report on Form 10-K, which was filed on February 29, 2008 and is incorporated herein by reference.
*10.45	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 4, 2009 and is incorporated herein by reference.
*10.46	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 4, 2009 and is incorporated herein by reference.
*10.47	Form of Restricted Stock Unit Agreement, relating to restricted stock units granted under the Company's 2008 Management Incentive Plan, which was filed as Exhibit 10.3 to the Company's current report on Form 8-K, which was filed on May 4, 2009 and is incorporated herein by reference.
*10.48	Form of Notice of Restricted Stock Unit Award, relating to restricted stock units granted under the Company's 2008 Management Incentive Plan, which was filed as Exhibit 10.4 to the Company's current report on Form 8-K, which was filed on May 4, 2009 and is incorporated herein by reference.
*10.49	Employment Agreement, dated July 28, 2009 between Karen S. Rohan and Magellan Health Services, Inc., which was filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2009, which was filed on July 31, 2009 and is incorporated herein by reference.
*10.50	Amendment to Employment Agreement, dated July 28, 2009 between Magellan Health Services, Inc. and Karen S. Rohan, which was filed as Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2009, which was filed on July 31, 2009 and is incorporated herein by reference.
*10.51	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.
*10.52	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.
*10.53	Form of Restricted Stock Unit Agreement, relating to restricted stock units granted under the Company's 2008 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 5, 2010 and is incorporated herein by reference.

Table of Contents

Exhibit No.	Description of Exhibit
*10.54	Form of Notice of Restricted Stock Unit Award, relating to restricted stock units granted under the Company's 2008 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 5, 2010 and is incorporated herein by reference.
*10.55	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.
*10.56	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.
*10.57	Form of Restricted Stock Unit Agreement, relating to restricted stock units granted under the Company's 2008 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, 2011 and is incorporated herein by reference.
*10.58	Form of Notice of Restricted Stock Unit Award, relating to restricted stock units granted under the Company's 2008 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, 2011 and is incorporated herein by reference.
*10.59	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.
*10.60	Magellan Health Services, Inc. 2011 Employee Stock Purchase Plan, effective as of May 18, 2011, which was filed as Appendix B to the Company's Definitive Proxy Statement, which was filed on April 8, 2011, and is incorporated herein by reference.
*10.61	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.
*10.62	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.
*10.63	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, 2012 and is incorporated herein by reference.
*10.64	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, 2012 and is incorporated herein by reference.

Table of Contents

Exhibit No.	Description of Exhibit
*10.65	Amendment to Employment Agreement, dated December 10, 2012 between Magellan Health Services, Inc. and Rene Lerer, M.D., which was filed as Exhibit 10.1 to the Company's current report on Form 8-K, which was filed on December 12, 2012, and is incorporated herein by reference.
*10.66	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.
*10.67	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.
*10.68	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.
*10.69	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.
*10.70	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.
*10.71	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.
*10.72	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.
*10.73	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.
*10.74	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.
*10.75	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.

Table of Contents

Exhibit No.	Description of Exhibit
*10.76	Amendment to Employment Agreement, dated April 3, 2013 between Magellan Health Services, Inc. and Tina Blasi, which was filed as Exhibit 10.1 to the Company's current report on Form 8-K, which was filed on April 8, 2013, and is incorporated herein by reference.
*10.77	Amendment to Employment Agreement, dated May 14, 2013 between Magellan Health Services, Inc. and Rene Lerer, M.D., which was filed as Exhibit 10.1 to the Company's current report on Form 8-K, which was filed on May 14, 2013, and is incorporated herein by reference.
10.78	Agreement and Plan of Merger, dated September 6, 2013, among Magellan Health Services, Inc., Cactus Acquisition LLC, Partners Rx Management LLC, and Holder Repco LLC, which was filed as Exhibit 10.1 to the Company's current report on Form 8-K, which was filed on October 1, 2013, and is incorporated herein by reference.
*10.79	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.
*10.80	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.
*10.81	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.
*10.82	Form of Notice of 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.
*10.83	Magellan Health Services, Inc. 2014 Employee Stock Purchase Plan, effective as of May 21, 2014, which was filed as Exhibit A to the Company's Definitive Proxy Statement, which was filed on April 10, 2014, and is incorporated herein by reference.
*10.84	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.
*10.85	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.
*10.86	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.

Table of Contents

Exhibit No.	Description of Exhibit
*10.87	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.
*10.88	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.
*10.89	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.
*10.90	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.
*10.91	Separation Agreement, dated June 3, 2015, between the Company and Tina Blasi, which was filed as Exhibit 10.2 to the Company's quarterly report on Form 10-Q, which was filed on July 27, 2015 and is incorporated herein by reference.
*10.92	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.
#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, 2015 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.

Table of Contents

(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 Item 14(d):

(1) Not applicable.

(2) Not applicable.

(3) Information with respect to this item is contained on page S-1 of this Report on Form 10-K.

4. Additional Information

The Company will provide to any person without charge, upon request, a copy of its annual Report on Form 10-K (without exhibits) for the year ended December 31, 2015, as filed with the Securities and Exchange Commission. 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 documents referred to above and other Securities and Exchange Commission filings of the Company are available on the Company's website at *www.magellanhealth.com*. 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.

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 29, 2016

/s/ JONATHAN N. RUBIN

Jonathan N. Rubin
Executive Vice President and Chief Financial Officer
(Principal Financial Officer)

Date: February 29, 2016

/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 29, 2016
/s/ ERAN BROSHY Eran Broshy	Director	February 29, 2016
/s/ MICHAEL DIAMENT Michael Diament	Director	February 29, 2016
/s/ WILLIAM J. MCBRIDE William J. McBride	Director	February 29, 2016
/s/ MICHAEL P. RESSNER Michael P. Ressner	Director	February 29, 2016
/s/ MARY SAMMONS Mary Sammons	Director	February 29, 2016

Table of Contents

Signature	Title	Date
/s/ PERRY FINE Perry Fine	Director	February 29, 2016
/s/ KAY COLES JAMES Kay Coles James	Director	February 29, 2016
/s/ DR. JOHN O. AGWUNOBI Dr. John O. Agwunobi	Director	February 29, 2016
/s/ JONATHAN N. RUBIN Jonathan N. Rubin	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 29, 2016
/s/ JEFFREY N. WEST Jeffrey N. West	Senior Vice President and Controller (Principal Accounting Officer)	February 29, 2016

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:

The following financial statement schedule of the registrant and its subsidiaries is submitted herewith in response to Item 15(a)2:

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

The Board of Directors and Stockholders of Magellan Health, Inc.

We have audited the accompanying consolidated balance sheets of Magellan Health, Inc. and subsidiaries as of December 31, 2014 and 2015, and 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, 2015. Our audits also included the financial statement schedule listed in the Index at Item 15(a)2. These financial statements and schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements and schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Magellan Health, Inc. and subsidiaries at December 31, 2014 and 2015, and the consolidated results of their operations and their cash flows for each of the three years in the period ended December 31, 2015, in conformity with U.S. generally accepted accounting principles. Also in our opinion, the related financial statement schedule, when considered in relation to the basic financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Magellan Health, Inc.'s internal control over financial reporting as of December 31, 2015, based on 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 29, 2016 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Baltimore, Maryland
February 29, 2016

Table of Contents

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS AS OF DECEMBER 31,

(In thousands, except per share amounts)

	2014	2015
ASSETS		
Current Assets:		
Cash and cash equivalents	$ 255,303	$ 115,432
Restricted cash	215,325	133,597
Accounts receivable, less allowance for doubtful accounts of $4,047 and $3,246 at December 31, 2014 and 2015, respectively	353,713	428,644
Short-term investments (restricted investments of $132,808 and $277,556 at December 31, 2014 and 2015, respectively)	224,361	322,339
Pharmaceutical inventory	39,375	50,749
Other current assets (restricted deposits of $30,620 and $27,752 at December 31, 2014 and 2015, respectively)	52,246	46,921
Total Current Assets	1,140,323	1,097,682
Property and equipment, net	171,916	174,745
Restricted long-term investments	43,293	3,826
Deferred income taxes	3,692	26,836
Other long-term assets	9,895	11,207
Goodwill	566,106	621,390
Other intangible assets, net	133,718	133,374
Total Assets	$ 2,068,943	$ 2,069,060

	2014	2015
LIABILITIES, REDEEMABLE NON-CONTROLLING INTEREST AND STOCKHOLDERS' EQUITY		
Current Liabilities:		
Accounts payable	$ 63,929	$ 86,484
Accrued liabilities	146,617	139,726
Short-term contingent consideration	8,314	91,623
Medical claims payable	278,482	250,449
Other medical liabilities	72,719	136,939
Current maturities of long-term debt and capital lease obligations	15,779	19,014
Total Current Liabilities	585,840	724,235
Long-term debt and capital lease obligations	254,062	238,295
Deferred income taxes	7,416	
Tax contingencies	12,320	12,677
Long-term contingent consideration	49,839	803
Deferred credits and other long-term liabilities	19,951	20,930
Total Liabilities	929,428	996,940
Redeemable non-controlling interest	5,957	5,937
Preferred stock, par value $.01 per share		
Authorized 10,000 shares at December 31, 2014 and 2015 Issued and outstanding none		
Ordinary common stock, par value $.01 per share		
	501	513

Authorized 100,000 shares at December 31, 2014 and 2015 Issued and outstanding 50,085 shares and 26,935 shares at December 31, 2014, respectively, and 51,340 and 24,692 shares at December 31, 2015, respectively		
Multi-Vote common stock, par value $.01 per share		
Authorized 40,000 shares at December 31, 2014 and 2015 Issued and outstanding none		
Other Stockholders' Equity:		
Additional paid-in capital	1,018,266	1,124,013
Retained earnings	1,179,897	1,211,310
Accumulated other comprehensive loss	(143)	(262)
Ordinary common stock in treasury, at cost, 23,150 shares and 26,648 shares at December 31, 2014 and 2015, respectively	(1,064,963)	(1,269,391)
Total Stockholders' Equity	1,133,558	1,066,183
Total Liabilities, Redeemable Non-Controlling Interest and Stockholders' Equity	$ 2,068,943	$ 2,069,060

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)

	2013	2014	2015
Net revenue:			
Managed care and other	$ 3,063,049	$ 2,968,374	$ 3,197,645
PBM and dispensing	483,268	791,744	1,399,755
Total net revenue	3,546,317	3,760,118	4,597,400
Costs and expenses:			
Cost of care	2,232,976	2,088,595	2,274,755
Cost of goods sold	455,601	732,949	1,321,877
Direct service costs and other operating expenses (1)(2)	619,546	723,498	822,392
Depreciation and amortization	71,994	91,070	102,844
Interest expense	3,000	7,387	6,581
Interest and other income	(1,985)	(1,301)	(2,165)
Total costs and expenses	3,381,132	3,642,198	4,526,284
Income before income taxes	165,185	117,920	71,116
Provision for income taxes	39,924	43,689	42,409
Net income	125,261	74,231	28,707
Less: net income (loss) attributable to non-controlling interest		(5,173)	(2,706)
Net income attributable to Magellan Health, Inc.	$ 125,261	$ 79,404	$ 31,413
Net income per common share attributable to Magellan Health, Inc.:			
Basic	$ 4.63	$ 2.98	$ 1.26
Diluted	$ 4.53	$ 2.90	$ 1.21

(1) Includes stock compensation expense of $21,252, $40,584 and $50,384 for the years ended December 31, 2013, 2014 and 2015, respectively.

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

See accompanying notes to consolidated financial statements.

Table of Contents

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME
FOR THE YEARS ENDED DECEMBER 31,

(In thousands)

	2013	2014	2015
Net income	$ 125,261	$ 74,231	$ 28,707
Other comprehensive income (loss):			
Unrealized losses on available-for-sale securities(1)	(58)	(50)	(119)
Comprehensive income	125,203	74,181	28,588
Less: comprehensive income (loss) attributable to non-controlling interest		(5,173)	(2,706)
Comprehensive income attributable to Magellan Health, Inc.	$ 125,203	$ 79,354	$ 31,294

(1) Net of income tax benefit of $(38), $(33) and $(68) for the years ended December 31, 2013, 2014 and 2015, 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				
Balance at December 31, 2012	45,928	$ 459	(18,575)	$ (806,561)	$ 848,238	$ 975,232	$ (35)	$ 1,017,333
Stock compensation expense					21,252			21,252
Exercise of stock options	1,139	12			47,281			47,293
Tax benefit from exercise of stock options and vesting of stock awards					2,297			2,297
Issuance of equity	284	3			(596)			(593)
Repurchase of stock			(1,160)	(60,153)				(60,153)
Adjustment to additional paid in capital due to reversal of tax contingency					3,853			3,853
Net income attributable to Magellan Health, Inc.						125,261		125,261
Other comprehensive loss other							(58)	(58)
Balance at December 31, 2013	47,351	474	(19,735)	(866,714)	922,325	1,100,493	(93)	1,156,485
Stock compensation expense					40,584			40,584
Exercise of stock options	1,191	12			52,982			52,994
Tax benefit from exercise of stock options and vesting of stock awards					2,980			2,980
Issuance of equity	1,543	15			(369)			(354)
Repurchase of stock			(3,415)	(198,249)				(198,249)
Adjustment to additional paid in capital due to reversal of tax contingency					2,591			2,591
Adjustment to non-controlling interest					(2,827)			(2,827)
Net income attributable to Magellan Health, Inc.						79,404		79,404
Other comprehensive loss other							(50)	(50)
Balance at December 31, 2014	50,085	501	(23,150)	(1,064,963)	1,018,266	1,179,897	(143)	1,133,558
Stock compensation expense					50,384			50,384
Exercise of stock options	1,140	11			54,079			54,090
Tax benefit from exercise of stock options and vesting of stock awards					3,530			3,530
Issuance of equity	115	1			408			409
Repurchase of stock			(3,498)	(204,428)				(204,428)
Adjustment to additional paid in capital due to reversal of tax contingency					32			32
Adjustment to non-controlling interest					(2,686)			(2,686)
Net income attributable to Magellan Health, Inc.						31,413		31,413
Other comprehensive loss other							(119)	(119)
Balance at December 31, 2015	51,340	$ 513	(26,648)	$ (1,269,391)	$ 1,124,013	$ 1,211,310	$ (262)	$ 1,066,183

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)

	2013	2014	2015
Cash flows from operating activities:			
Net income	$ 125,261	$ 74,231	$ 28,707
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	71,994	91,070	102,844
Non-cash interest expense	736	3,987	399
Non-cash stock compensation expense	21,252	40,584	50,384
Non-cash income tax benefit	(1,212)	(4,291)	(26,999)
Non-cash amortization on investments	9,107	5,050	7,118
Cash flows from changes in assets and liabilities, net of effects from acquisitions of businesses:			
Restricted cash	(2,242)	21,371	81,728
Accounts receivable, net	(40,804)	(74,604)	(52,394)
Pharmaceutical inventory	(3,882)	10,234	(11,374)
Other assets	(9,293)	(7,557)	4,149
Accounts payable and accrued liabilities	3,593	5,887	(36,043)
Medical claims payable and other medical liabilities	17,866	55,670	36,187
Contingent consideration			55,035
Tax contingencies	(22,960)	(14,955)	(1,021)
Deferred credits and other long-term liabilities	10,988	4,045	294
Other	2,757	322	171
Net cash provided by operating activities	183,161	211,044	239,185
Cash flows from investing activities:			
Capital expenditures	(64,542)	(62,337)	(71,584)
Acquisitions and investments in businesses, net of cash acquired	(107,541)	(128,277)	(55,818)
Purchase of investments	(323,253)	(340,961)	(470,093)
Maturity of investments	339,428	276,446	404,308
Net cash used in investing activities	(155,908)	(255,129)	(193,187)
Cash flows from financing activities:			
Proceeds from issuance of debt		250,000	
Payments to acquire treasury stock	(60,677)	(197,533)	(206,044)
Proceeds from exercise of stock options and warrants	47,529	52,994	53,493
Payments on long-term debt and capital lease obligations	(3,001)	(8,045)	(17,038)
Payments on contingent consideration			(20,762)
Tax benefit from exercise of stock options and vesting of stock awards	3,212	3,218	4,073
Other	(593)	(4,433)	409
Net cash (used in) provided by financing activities	(13,530)	96,201	(185,869)
Net increase (decrease) in cash and cash equivalents	13,723	52,116	(139,871)
Cash and cash equivalents at beginning of period	189,464	203,187	255,303
Cash and cash equivalents at end of period	$ 203,187	$ 255,303	$ 115,432

See accompanying notes to consolidated financial statements.

Table of Contents

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2015

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 engaged in the healthcare management business, and is focused on managing the fastest growing, most complex areas of health, 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 health outcomes and optimize the cost of care for the members 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").

Effective as of July 1, 2015, the Company reorganized into two business units Magellan Healthcare and Magellan Rx Management, which are supported by corporate functions. As a result of this business reorganization, the Company concluded that changes to its reportable segments were warranted, with the Healthcare segment ("Healthcare") comprised of the operating segments previously defined as the Commercial, Public Sector and the Specialty Solutions segments. Prior period balances have been reclassified to reflect this change. The Company's business is divided into the following segments, which are differentiated based on the services it provides, as described below.

Healthcare

Healthcare includes the Company's: (i) management of behavioral healthcare services and employee assistance program ("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 ("MCC"). These special populations include individuals with serious mental illness ("SMI"), dual eligibles, long-term services and supports and other populations with unique and often complex healthcare needs.

The Company's coordination and management of these healthcare services are provided through its comprehensive network of medical and 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 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. 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 Healthcare segment's commercial division serves a variety of customers, with services, inclusive of special population management, provided under contracts with health plans and accountable care organizations for some or all of their commercial, Medicaid and Medicare members, as well as with

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

December 31, 2015

1. General (Continued)

employers. The government division contracts with local, state and federal governmental agencies to provide services to recipients under Medicaid, Medicare and other government programs.

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 and (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.

Pharmacy Management

The Pharmacy Management segment ("Pharmacy Management") 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) pharmacy benefit management ("PBM") services; (ii) pharmacy benefit administration ("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 across both the medical and pharmacy benefit that treat complex conditions, regardless of site of service, method of delivery, or benefit reimbursement.

Pharmacy Management's services are provided under contracts with health plans, employers, managed care organizations, state Medicaid programs, Medicare Part D and other government agencies, and encompass risk-based and fee-for-service ("FFS") arrangements. In addition, Pharmacy Management has subcontract arrangements to provide PBM services for certain Healthcare customers.

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.

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"), which is a new comprehensive revenue recognition standard that will supersede virtually all existing revenue guidance under GAAP. In July 2015, the FASB approved to defer the effective date of ASU 2014-09. This ASU is now effective for calendar years beginning after December 15, 2017. 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 June 2014, the FASB issued ASU No. 2014-12, "Accounting for Share-Based Payments When the Terms of an Award Provide That a Performance Target Could Be Achieved After the Requisite Service Period" ("ASU 2014-12"), which revises the accounting treatment for stock compensation tied

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

December 31, 2015

2. Summary of Significant Accounting Policies (Continued)

to performance targets. This ASU is effective for calendar years beginning after December 15, 2015. The guidance is not expected to materially impact the Company's consolidated results of operations, financial position or cash flows.

In August 2014, the FASB issued ASU No. 2014-15, "Disclosure of Uncertainties about an Entity's Ability to Continue as a Going Concern" ("ASU 2014- 15"), which provides guidance in GAAP about management's responsibility to evaluate whether there is substantial doubt about an entity's ability to continue as a going concern and to provide related footnote disclosures. This amendment should reduce diversity in the timing and content of footnote disclosures. This ASU is effective for the annual period beginning after December 15, 2016 and for annual and interim reporting periods thereafter. The guidance is not expected to materially impact the Company's consolidated results of operations, financial position or cash flows.

In February 2015, the FASB issued ASU No. 2015-02, "Amendments to the Consolidation Analysis" ("ASU 2015-02"), which amends certain requirements for determining whether a variable interest entity must be consolidated. The amendments are effective for annual and interim reporting periods of public entities beginning after December 31, 2015. The guidance is not expected to materially impact the Company's consolidated results of operations, financial position or cash flows.

In April 2015, the FASB issued ASU No. 2015-03, "Simplifying the Presentation of Debt Issuance Costs" ("ASU 2015-03"). The amendments in this ASU require that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts. This guidance is effective for annual and interim reporting periods of public entities beginning after December 15, 2015. The Company elected to adopt the guidance effective for the fiscal year ended December 31, 2015 and apply it retrospectively for all periods presented.

In April 2015, the FASB issued ASU No. 2015-05, "Customer's Accounting for Fees Paid in a Cloud Computing Arrangement" ("ASU 2015-05"), which provides guidance to clarify the customer's accounting for fees paid in a cloud computing arrangement. This guidance is effective for annual and interim reporting periods of public entities beginning after December 15, 2015. The guidance is not expected to materially impact the Company's consolidated results of operations, financial position or cash flows.

In July 2015, the FASB issued ASU No. 2015-11, "Simplifying the Measurement of Inventory" ("ASU 2015-11"). The amendment under this ASU requires that an entity measure inventory at the lower of cost or net realizable value. This guidance is effective for annual and interim reporting periods of public entities beginning after December 15, 2016. The guidance is not expected to materially impact the Company's consolidated results of operations, financial position or cash flows.

In September 2015, the FASB issued ASU No. 2015-16, "Simplifying the Accounting for Measurement Period Adjustments" ("ASU 2015-16"). The amendment under this ASU requires that an acquirer recognize adjustments to provisional amounts that are identified during the measurement period in the reporting period in which the adjustment amounts are determined. This guidance is effective for annual and interim reporting periods of public entities beginning after December 15, 2015. The guidance is not expected to materially impact the Company's consolidated results of operations, financial position or cash flows.

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

December 31, 2015

2. Summary of Significant Accounting Policies (Continued)

In November 2015, the FASB issued ASU No. 2015-17, "Balance Sheet Classification of Deferred Taxes" ("ASU 2015-17"). The amendment under this ASU requires that deferred income tax liabilities and assets be classified as noncurrent. This guidance is effective for annual and interim reporting periods of public entities beginning after December 15, 2016, with early adoption permitted. The Company elected to adopt the guidance effective for the fiscal year ended December 31, 2015 and applied it retrospectively for all periods presented.

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. This guidance is effective for annual and iterim reporting periods of public entities beginning after December 15, 2018, 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 include, among other things, accounts receivable realization, valuation allowances for deferred tax assets, valuation of goodwill and intangible assets, medical claims payable, other medical liabilities, contingent consideration, stock compensation assumptions, tax contingencies and legal liabilities. Actual results could differ from those estimates.

Managed Care and Other Revenue

Managed Care Revenue. Managed care revenue, inclusive of revenue from the Company's risk, EAP and ASO contracts, is recognized over the applicable coverage period on a per member basis for covered members. The Company is paid a per member fee for all enrolled members, and this fee is recorded as revenue in the month in which members are entitled to service. The Company adjusts its revenue for retroactive membership terminations, additions and other changes, when such adjustments are identified, with the exception of retroactivity that can be reasonably estimated. The impact of retroactive rate amendments is generally recorded in the accounting period that terms to the amendment are finalized, and that the amendment is executed. Any fees paid prior to the month of service are recorded as deferred revenue. Managed care revenues approximated $2.7 billion, $2.6 billion and $2.7 billion for the years ended December 31, 2013, 2014 and 2015, respectively.

Fee-For-Service and Cost-Plus Contracts. The Company has certain fee-for-service contracts, including cost-plus contracts, with customers under which the Company recognizes revenue as services are performed and as costs are incurred. This includes revenues received in relation to the Patient Protection and Affordable Care Act health insurer fee ("HIF fee") billed on a cost reimbursement basis. Revenues from these contracts approximated $215.1 million, $290.9 million and $342.0 million for the years ended December 31, 2013, 2014 and 2015, respectively.

Rebate Revenue. The Company administers a rebate program for certain clients through which the Company coordinates the achievement, calculation and collection of rebates and administrative fees

Table of Contents

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

December 31, 2015

2. Summary of Significant Accounting Policies (Continued)

from pharmaceutical manufacturers on behalf of clients. Each period, the Company estimates the total rebates earned based on actual volumes of pharmaceutical purchases by the Company's clients, as well as historical and/or anticipated sharing percentages. The Company earns fees based upon the volume of rebates generated for its clients. The Company does not record as rebate revenue any rebates that are passed through to its clients. Total rebate revenues for the years ended December 31, 2013, 2014 and 2015 approximated $34.8 million, $43.6 million and $88.7 million, respectively.

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.

PBM and Dispensing Revenue

Pharmacy Benefit Management Revenue. The Company recognizes PBM revenue, which consists of a negotiated prescription price (ingredient cost plus dispensing fee), co-payments collected by the pharmacy and any associated administrative fees, when claims are adjudicated. 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 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. PBM revenues approximated $106.7 million, $575.7 million and $1.2 billion for the years ended December 31, 2013, 2014 and 2015, respectively.

Dispensing Revenue. The Company recognizes dispensing revenue, which includes the co-payments received from members of the health plans the Company serves, when the specialty pharmaceutical drugs are shipped. 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. Revenues from the dispensing of specialty pharmaceutical drugs on behalf of health plans approximated $376.6 million, $216.0 million and $211.6 million for the years ended December 31, 2013, 2014 and 2015, respectively.

Significant Customers

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

Through December 31, 2015, the Company provided 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 terminated on December 31, 2015. The Iowa Contracts generated net revenues of $321.1 million, $465.0 million and $530.3 million for the years ended December 31, 2013, 2014 and 2015, respectively.

Table of Contents

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

December 31, 2015

2. Summary of Significant Accounting Policies (Continued)

Through March 31, 2014, the Company provided behavioral healthcare management and other related services to approximately 680,000 members in Maricopa County, Arizona as the Regional Behavioral Health Authority for GSA6 ("Maricopa County") pursuant to a contract with the State of Arizona (the "Maricopa Contract"). The Maricopa Contract was for the management of the publicly funded behavioral health system that delivered mental health, substance abuse and crisis services for adults, youth and children. The Maricopa Contract terminated on March 31, 2014. The Maricopa Contract generated net revenues of $755.0 million and $216.6 million for the years ended December 31, 2013 and 2014, respectively.

Customers exceeding ten percent of segment net revenues

In addition to the Iowa Contracts and the Maricopa 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, 2013, 2014 and 2015 (in thousands):

Segment	Term Date	2013	2014	2015
Healthcare				
Customer A	December 31, 2018(1)	$ 128,607*	$ 253,661*	$ 439,481
Pharmacy Management				
Customer B	November 30, 2016 to December 31, 2016(2)	133,724	123,812	130,200*
Customer C	December 31, 2016		171,936	324,809
Customer D	December 31, 2013	92,647	2,612*	

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

(1) The Company had behavioral healthcare contracts with various areas in the State of Florida (the "Florida Areas") which were part of the Florida Medicaid program. The State of Florida implemented a new system of mandated managed care through which Medicaid enrollees receive integrated healthcare services, and phased out the behavioral healthcare programs under which the Florida Areas' contracts operated. The Company has a contract with the State of Florida to provide integrated healthcare services under the new program.

(2) The customer has more than one contract. The individual contracts are scheduled to terminate at various points during the time period indicated above.

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. Net revenues from the Pennsylvania Counties in the aggregate totaled $359.0 million, $369.9 million and $395.7 million for the years ended December 31, 2013, 2014 and 2015, respectively.

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

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

December 31, 2015

2. Summary of Significant Accounting Policies (Continued)

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.

Income Taxes

The Company files a consolidated federal income tax return with most of its eighty-percent or more controlled subsidiaries. The Company files a separate consolidated federal income tax return for AlphaCare of New York, Inc. ("AlphaCare") and its parent, AlphaCare Holdings, Inc. ("AlphaCare Holdings"). The Company and its 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. However, reversals of unrecognized tax benefits related to deductions for stock compensation in excess of the related book expense are recorded as increases in additional paid-in capital. To the extent reversals of unrecognized tax benefits cannot be specifically traced to these excess deductions due to complexities in the tax law, the Company records the tax benefit for such reversals to additional paid-in-capital on a pro-rata basis.

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

Table of Contents

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

December 31, 2015

2. Summary of Significant Accounting Policies (Continued)

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. For 2014 and 2015, the HIF fees were $21.4 million and $26.5 million, respectively, which have been paid and which is included in direct service costs and other operating expenses in the consolidated statements of income. The Company recorded revenues of $36.5 million and $45.4 million in the years ended December 31, 2014 and 2015, respectively, associated with the accrual for the reimbursement of the economic impact of the HIF fees from its customers.

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, 2015, the Company's excess capital and undistributed earnings for the Company's regulated subsidiaries of $85.3 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, 2014 and 2015 were as follows (in thousands):

	2014	2015
Restricted cash	$ 215,325	$ 133,597
Restricted short-term investments	132,808	277,556
Restricted deposits (included in other current assets)	30,620	27,752
Restricted long-term investments	43,293	3,826
Total	$ 422,046	$ 442,731

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).

Table of Contents

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

December 31, 2015

2. Summary of Significant Accounting Policies (Continued)

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, 2014 and 2015 (in thousands):

	Fair Value Measurements at December 31, 2014			
	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents(1)	$	$ 139,280	$	$ 139,280
Restricted cash(2)		65,992		65,992
Investments:				
U.S. Government and agency securities	4,303			4,303
Obligations of government-sponsored enterprises(3)		15,315		15,315
Corporate debt securities		246,886		246,886
Certificates of deposit		1,150		1,150
Total assets held at fair value	$ 4,303	$ 468,623	$	$ 472,926
Liabilities				
Contingent consideration	$	$	$ 58,153	$ 58,153
Total liabilities held at fair value	$	$	$ 58,153	$ 58,153

	Fair Value Measurements at December 31, 2015			
	Level 1	Level 2	Level 3	Total
Assets				
Cash and cash equivalents(4)	$	$ 6,009	$	$ 6,009
Restricted cash(5)		82,808		82,808
Investments:				
U.S. Government and agency securities	5,514			5,514
Obligations of government-sponsored enterprises(6)		50,525		50,525
Corporate debt securities		268,976		268,976
Certificates of deposit		1,150		1,150
Total assets held at fair value	$ 5,514	$ 409,468	$	$ 414,982