CENTENE CORP
Form 10-Q
October 23, 2012

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

[X] QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the quarterly period ended September 30, 2012
OR

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

For the transition period from to

Commission file number: 001-31826

CENTENE CORPORATION
(Exact name of registrant as specified in its charter)

Delaware (State or other jurisdiction of incorporation or organization)	42-1406317 (I.R.S. Employer Identification Number)
7700 Forsyth Boulevard St. Louis, Missouri (Address of principal executive offices)	63105 (Zip Code)

Registrant's telephone number, including area code:

(314) 725-4477

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (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). x Yes ¨ No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer" and "small reporting

company" in Rule 12b-2 of the Exchange Act. Large accelerated filer x Accelerated filer ¨ Non-accelerated filer ¨ (do not check if a smaller reporting company) Smaller reporting company ¨

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

As of October 12, 2012, the registrant had 51,633,824 shares of common stock outstanding.

CENTENE CORPORATION
QUARTERLY REPORT ON FORM 10-Q
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CAUTIONARY STATEMENT ON FORWARD-LOOKING STATEMENTS

All statements, other than statements of current or historical fact, contained in this filing are forward-looking statements. We have attempted to identify these statements by terminology including “believe,” “anticipate,” “plan,” “expect,” “estimate,” “intend,” “seek,” “target,” “goal,” “may,” “will,” “should,” “can,” “continue” and other similar words or expressions in connection with, among other things, any discussion of future operating or financial performance. In particular, these statements include statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, including those entitled “Management’s Discussion and Analysis of Financial Condition and Results of Operations,” and Part II, Item 1A. “Risk Factors.” Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, including economic, regulatory, competitive and other factors that may cause our or our industry’s actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

All forward-looking statements included in this filing are based on information available to us on the date of this filing and we undertake no obligation to update or revise the forward-looking statements included in this filing, whether as a result of new information, future events or otherwise, after the date of this filing. Actual results may differ from projections or estimates due to a variety of important factors, including:

- our ability to accurately predict and effectively manage health benefits and other operating expenses;
- competition;
- membership and revenue projections;
- timing of regulatory contract approval;
- changes in healthcare practices;
- changes in federal or state laws or regulations, including the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act and any regulations enacted thereunder;
- changes in expected contract start dates;
- inflation;
- provider and state contract changes;
- new technologies;
- reduction in provider payments by governmental payors;
- major epidemics;
- disasters and numerous other factors affecting the delivery and cost of healthcare;
- the expiration, cancellation or suspension of our Medicaid managed care contracts by state governments;
- availability of debt and equity financing, on terms that are favorable to us; and
- general economic and market conditions.

Non-GAAP Financial Presentation

The Company is providing certain non-GAAP financial measures in this release as the Company believes that these figures are helpful in allowing individuals to more accurately assess the ongoing nature of the Company's operations and measure the Company's performance more consistently. The Company uses the presented non-GAAP financial measures such as internally to allow management to focus on period-to-period changes in the Company's core business operations. Therefore, the Company believes that this information is meaningful in addition to the information contained in the GAAP presentation of financial information. The presentation of this additional non-GAAP financial information is not intended to be considered in isolation or as a substitute for the financial information prepared and presented in accordance with GAAP.

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PART I
FINANCIAL INFORMATION

ITEM 1. Financial Statements.
CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(In thousands, except share data)
(Unaudited)

	September 30, 2012	December 31, 2011
ASSETS		
Current assets:		
Cash and cash equivalents	$796,621	$573,698
Premium and related receivables	316,123	157,450
Short-term investments	139,920	130,499
Other current assets	123,841	78,363
Total current assets	1,376,505	940,010
Long-term investments	559,714	506,140
Restricted deposits	33,509	26,818
Property, software and equipment, net	381,781	349,622
Goodwill	256,288	281,981
Intangible assets, net	21,375	27,430
Other long-term assets	61,764	58,335
Total assets	$2,690,936	$2,190,336
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$919,032	$607,985
Premium deficiency reserve	63,000	—
Accounts payable and accrued expenses	162,778	216,504
Unearned revenue	131,967	9,890
Current portion of long-term debt	3,337	3,234
Total current liabilities	1,280,114	837,613
Long-term debt	391,973	348,344
Other long-term liabilities	61,785	67,960
Total liabilities	1,733,872	1,253,917
Commitments and contingencies		
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; 54,405,296 issued and 51,632,704 outstanding at September 30, 2012, and 53,586,726 issued and 50,864,618 outstanding at December 31, 2011	54	54
Additional paid-in capital	458,741	421,981
Accumulated other comprehensive income:		
Unrealized gain on investments, net of tax	6,702	5,761
Retained earnings	557,759	564,961
Treasury stock, at cost (2,772,592 and 2,722,108 shares, respectively)	(59,277)	(57,123)
Total Centene stockholders' equity	963,979	935,634
Noncontrolling interest	(6,915)	785
Total stockholders' equity	957,064	936,419

Total liabilities and stockholders' equity	$2,690,936	$2,190,336

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

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CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS
(In thousands, except share data)
(Unaudited)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2012	2011	2012	2011
Revenues:				
Premium	$2,184,061	$1,239,464	$5,853,469	$3,640,829
Service	28,403	25,817	84,062	81,629
Premium and service revenues	2,212,464	1,265,281	5,937,531	3,722,458
Premium tax	235,657	36,754	333,484	110,948
Total revenues	2,448,121	1,302,035	6,271,015	3,833,406
Expenses:				
Medical costs	2,036,999	1,053,320	5,370,080	3,091,007
Cost of services	21,744	20,229	66,897	60,717
General and administrative expenses	181,073	142,934	512,322	427,067
Premium tax expense	235,946	37,005	333,872	111,668
Impairment loss	—	—	28,033	—
Total operating expenses	2,475,762	1,253,488	6,311,204	3,690,459
Earnings (loss) from operations	(27,641)	48,547	(40,189)	142,947
Other income (expense):				
Investment and other income	23,244	2,697	32,580	9,379
Debt extinguishment costs	—	—	—	(8,488)
Interest expense	(4,855)	(4,572)	(14,393)	(15,523)
Earnings (loss) from operations, before income tax expense	(9,252)	46,672	(22,002)	128,315
Income tax expense (benefit)	(9,547)	18,459	(6,068)	49,216
Net earnings (loss)	295	28,213	(15,934)	79,099
Noncontrolling interest	(3,524)	(774)	(8,732)	(2,007)
Net earnings (loss) attributable to Centene Corporation	$3,819	$28,987	$(7,202)	$81,106
Net earnings (loss) per common share attributable to Centene Corporation:				
Basic earnings (loss) per common share	$0.07	$0.58	$(0.14)	$1.62
Diluted earnings (loss) per common share	$0.07	$0.55	$(0.14)	$1.55
Weighted average number of common shares outstanding:				
Basic	51,584,860	50,345,512	51,393,345	50,089,845
Diluted	53,806,197	52,620,350	51,393,345	52,320,906

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

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CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENT OF COMPREHENSIVE EARNINGS
(In thousands)
(Unaudited)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2012	2011	2012	2011
Net earnings (loss)	$295	$28,213	$(15,934)	$79,099
Reclassification adjustment, net of tax	1,023	195	1,495	415
Change in unrealized gains on investments, net of tax	(163)	(900)	(554)	(361)
Other comprehensive earnings (loss)	860	(705)	941	54
Comprehensive earnings (loss)	1,155	27,508	(14,993)	79,153
Comprehensive earnings (loss) attributable to the noncontrolling interest	(3,524)	(774)	(8,732)	(2,007)
Comprehensive earnings (loss) attributable to Centene Corporation	$4,679	$28,282	$(6,261)	$81,160

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

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CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENT OF STOCKHOLDERS' EQUITY
(In thousands, except share data)
(Unaudited)

Nine Months Ended September 30, 2012

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Income	Retained Earnings	$.001 Par Value Shares	Amt	Non controlling Interest	Total
Balance, December 31, 2011	53,586,726	$54	$421,981	$5,761	$564,961	2,722,108	$(57,123)	$785	$936,419
Comprehensive Earnings:									
Net earnings (loss)	—	—	—	—	(7,202)	—	—	(8,732)	(15,934)
Change in unrealized investment gain, net of $623 tax	—	—	—	941	—	—	—	—	941
Total comprehensive earnings (loss)									(14,993)
Common stock issued for employee benefit plans	818,570	—	12,297	—	—	—	—	—	12,297
Common stock repurchases	—	—	—	—	—	50,484	(2,154)	—	(2,154)
Stock compensation expense	—	—	18,417	—	—	—	—	—	18,417
Excess tax benefits from stock compensation	—	—	6,046	—	—	—	—	—	6,046
Contribution from noncontrolling interest	—	—	—	—	—	—	—	1,032	1,032
Balance, September 30, 2012	54,405,296	$54	$458,741	$6,702	$557,759	2,772,592	$(59,277)	$(6,915)	$957,064

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

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CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)
(Unaudited)

	Nine Months Ended September 30,	
	2012	2011
Cash flows from operating activities:		
Net earnings (loss)	$(15,934)	$79,099
Adjustments to reconcile net earnings (loss) to net cash provided by operating activities		
Depreciation and amortization	49,892	43,055
Stock compensation expense	18,417	13,263
Impairment loss	28,033	—
Gain on sale of investment in convertible note	(17,880)	—
Gain on sale of investments, net	(1,460)	(213)
Debt extinguishment costs	—	8,488
Deferred income taxes	(19,318)	(223)
Changes in assets and liabilities		
Premium and related receivables	(139,414)	(13,306)
Other current assets	(23,487)	(6,667)
Other assets	1,918	(1,230)
Medical claims liabilities	374,046	40,476
Unearned revenue	122,077	(65,183)
Accounts payable and accrued expenses	(59,872)	(11,414)
Other operating activities	(9,736)	3,528
Net cash provided by operating activities	307,282	89,673
Cash flows from investing activities:		
Capital expenditures	(70,601)	(56,938)
Purchases of investments	(501,958)	(201,145)
Sales and maturities of investments	434,009	180,124
Investments in acquisitions, net of cash acquired	—	(3,192)
Net cash used in investing activities	(138,550)	(81,151)
Cash flows from financing activities:		
Proceeds from exercise of stock options	11,686	13,582
Proceeds from borrowings	215,000	419,183
Payment of long-term debt	(177,422)	(415,475)
Excess tax benefits from stock compensation	6,049	1,632
Common stock repurchases	(2,154)	(1,280)
Contribution from noncontrolling interest	1,032	569
Debt issue costs	—	(9,242)
Net cash provided by financing activities	54,191	8,969
Net increase in cash and cash equivalents	222,923	17,491
Cash and cash equivalents, beginning of period	573,698	434,166
Cash and cash equivalents, end of period	$796,621	$451,657
Supplemental disclosures of cash flow information:		
Interest paid	$12,127	$16,097
Income taxes paid	$34,001	$49,996

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

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CENTENE CORPORATION AND SUBSIDIARIES
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
(Dollars in thousands, except share data)
(Unaudited)

1. Basis of Presentation

The accompanying interim financial statements have been prepared under the presumption that users of the interim financial information have either read or have access to the audited financial statements included in the Form 10-K for the fiscal year ended December 31, 2011. The unaudited interim financial statements herein have been prepared pursuant to the rules and regulations of the Securities and Exchange Commission. Accordingly, footnote disclosures, which would substantially duplicate the disclosures contained in the December 31, 2011 audited financial statements, have been omitted from these interim financial statements where appropriate. In the opinion of management, these financial statements reflect all adjustments, consisting only of normal recurring adjustments, which are necessary for a fair presentation of the results of the interim periods presented.

Certain 2011 amounts in the consolidated financial statements have been reclassified to conform to the 2012 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

The Company reclassified certain Medical Costs and General & Administrative Expenses beginning with its financial results for the year ended December 31, 2011, as well as prior periods to conform to the current presentation, to more closely align to the National Association of Insurance Commissioners definition. For the three months ended September 30, 2011, the net impact of the reclassification increased Medical Costs and decreased General & Administrative Expense by $24,734. For the nine months ended September 30, 2011, the net impact of the reclassification increased Medical Costs and decreased General & Administrative Expense by $69,607.

2. Short-term and Long-term Investments and Restricted Deposits

Short-term and long-term investments and restricted deposits by investment type consist of the following:

	September 30, 2012				December 31, 2011			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$60,177	$760	$(6)	$60,931	$29,014	$638	$(13)	$29,639
Corporate securities	257,161	5,844	(6)	262,999	186,018	3,762	(751)	189,029
Restricted certificates of deposit	5,891	—	—	5,891	5,890	—	—	5,890
Restricted cash equivalents	13,150	—	—	13,150	13,775	—	—	13,775
Municipal securities:								
General obligation	91,259	1,649	—	92,908	126,806	2,828	(26)	129,608
Pre-refunded	16,529	130	—	16,659	33,247	465	—	33,712

Revenue	85,281	1,804	(25)	87,060	118,507	2,387	(34)	120,860
Variable rate demand notes	92,225	—	—	92,225	64,658	—	—	64,658
Asset backed securities	74,126	1,294	—	75,420	51,779	430	(17)	52,192
Cost and equity method investments	10,958	—	—	10,958	9,395	—	—	9,395
Life insurance contracts	14,942	—	—	14,942	14,699	—	—	14,699
Total	$721,699	$11,481	$(37)	$733,143	$653,788	$10,510	$(841)	$663,457

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The Company's investments are classified as available-for-sale with the exception of life insurance contracts and certain cost and equity method investments. The Company's investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets with the focus on high credit quality securities. The Company limits the size of investment in any single issuer other than U.S. treasury securities and obligations of U.S. government corporations and agencies. As of September 30, 2012, 38% of the Company's investments in securities recorded at fair value that carry a rating by Moody's or S&P were rated AAA, 68% were rated AA- or higher, and 99% were rated A- or higher. At September 30, 2012, the Company held certificates of deposit, life insurance contracts and cost and equity method investments which did not carry a credit rating.

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

	September 30, 2012				December 31, 2011			
	Less Than 12 Months		12 Months or More		Less Than 12 Months		12 Months or More	
	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$(4)	$1,196	$(2)	$202	$(13)	$2,184	$—	$—
Corporate securities	(6)	5,295	—	—	(751)	23,040	—	—
Municipal securities:								
General obligation	—	—	—	—	(26)	3,710	—	—
Revenue	(25)	1,825	—	—	(34)	12,597	—	—
Asset backed securities	—	—	—	—	(17)	20,417	—	—
Total	$(35)	$8,316	$(2)	$202	$(841)	$61,948	$—	$—

As of September 30, 2012, the gross unrealized losses were generated from 8 positions out of a total of 376 positions. The decline in fair value of fixed income securities is a result of movement in interest rates subsequent to the purchase of the security.

For each security in an unrealized loss position, the Company assesses whether it intends to sell the security or if it is more likely than not the Company will be required to sell the security before recovery of the amortized cost basis for reasons such as liquidity, contractual or regulatory purposes. If the security meets this criterion, the decline in fair value is other-than-temporary and is recorded in earnings. The Company does not intend to sell these securities prior to maturity and it is not likely that the Company will be required to sell these securities prior to maturity; therefore, there is no indication of other than temporary impairment for these securities.

The contractual maturities of short-term and long-term investments and restricted deposits are as follows:

	September 30, 2012				December 31, 2011			
	Investments		Restricted Deposits		Investments		Restricted Deposits	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value
One year or less	$138,508	$139,920	$33,108	$33,151	$129,232	$130,499	$19,666	$19,666
	423,533	432,717	358	358	406,140	413,953	7,085	7,152

One year through five years								
Five years through ten years	37,331	37,444	—	—	34,945	34,961	—	—
Greater than ten years	88,860	89,553	—	—	56,720	57,226	—	—
Total	$688,232	$699,634	$33,466	$33,509	$627,037	$636,639	$26,751	$26,818

Actual maturities may differ from contractual maturities due to call or prepayment options. Asset backed securities are included in the one year through five years category, while equity securities and life insurance contracts are included in the five years through ten years category. The Company has an option to redeem at amortized cost substantially all of the securities included in the Greater than ten years category listed above.

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Realized gains and losses are determined on the basis of specific identification or a first-in, first-out methodology, if specific identification is not practicable. The Company's gross recorded realized gains and losses were as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2012	2011	2012	2011
Gains	$1,475	$107	$1,483	$240
Losses	(12)	(1)	(23)	(27)
Net realized gains	$1,463	$106	$1,460	$213

During the third quarter of 2012, the company recognized $1,463 in net gains primarily as a result of the liquidation of $75,468 of investments held by the Georgia health plan in order to meet short-term liquidity needs due to the delays in premium receipts.

The Company continuously monitors investments for other-than-temporary impairment. Certain investments have experienced a decline in fair value due to changes in credit quality, market interest rates and/or general economic conditions. The Company recognizes an impairment loss for cost and equity method investments when evidence demonstrates that it is other-than-temporarily impaired. Evidence of a loss in value that is other than temporary may include the absence of an ability to recover the carrying amount of the investment or the inability of the investee to sustain a level of earnings that would justify the carrying amount of the investment.

Investment amortization of $8,676 and $7,545 was recorded in the nine months ended September 30, 2012 and 2011, respectively.

3. Fair Value Measurements

Assets and liabilities recorded at fair value in the consolidated balance sheets are categorized based upon the extent to which the fair value estimates are based upon observable or unobservable inputs. Level inputs are as follows:

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

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The following table summarizes fair value measurements by level at September 30, 2012, for assets and liabilities measured at fair value on a recurring basis:

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$796,621	—	—	$796,621
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$34,409	$12,054	—	$46,463
Corporate securities	—	262,999	—	262,999
Municipal securities:				
General obligation	—	92,908	—	92,908
Pre-refunded	—	16,659	—	16,659
Revenue	—	87,060	—	87,060
Variable rate demand notes	—	92,225	—	92,225
Asset backed securities	—	75,420	—	75,420
Total investments	$34,409	$639,325	—	$673,734
Restricted deposits available for sale:				
Cash and cash equivalents	$13,150	—	—	$13,150
Certificates of deposit	5,891	—	—	5,891
U.S. Treasury securities and obligations of U.S. government corporations and agencies	13,958	$510	—	14,468
Total restricted deposits	$32,999	$510	—	$33,509
Other long-term assets: Interest rate swap contract	—	$17,196	—	$17,196
Total assets at fair value	$864,029	$657,031	—	$1,521,060

The following table summarizes fair value measurements by level at December 31, 2011, for assets and liabilities measured at fair value on a recurring basis:

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$573,698	—	—	$573,698
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$17,091	$5,395	—	$22,486
Corporate securities	—	189,029	—	189,029
Municipal securities:				
General obligation	—	129,608	—	129,608
Pre-refunded	—	33,712	—	33,712
Revenue	—	120,860	—	120,860
Variable rate demand notes	—	64,658	—	64,658
Asset backed securities	—	52,192	—	52,192
Total investments	$17,091	$595,454	—	$612,545
Restricted deposits available for sale:				
Cash and cash equivalents	$13,775	—	—	$13,775
Certificates of deposit	5,890	—	—	5,890
U.S. Treasury securities and obligations of U.S. government corporations and agencies	7,153	—	—	7,153
Total restricted deposits	$26,818	—	—	$26,818
Other long-term assets: Interest rate swap contract	—	$11,431	—	$11,431
Total assets at fair value	$617,607	$606,885	—	$1,224,492

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The Company periodically transfers U.S. Treasury securities and obligations of U.S. government corporations and agencies between Level I and Level II fair value measurements dependent upon the level of trading activity for the specific securities at the measurement date. The Company's policy regarding the timing of transfers between Level I and Level II is to measure and record the transfers at the end of the reporting period. At September 30, 2012, there were $1,818 of transfers from Level I to Level II and $3,612 of transfers from Level II to Level I. The Company utilizes matrix pricing services to estimate fair value for securities which are not actively traded on the measurement date. The Company designates these securities as Level II fair value measurements. The aggregate carrying amount of the Company's life insurance contracts and other non-majority owned investments, which approximates fair value, was $25,900 and $24,094 as of September 30, 2012 and December 31, 2011, respectively.

4. Notes Receivable

Between July 2008 and October 2011, the Company made an investment of $30,000 in secured notes receivable to a third party as part of an investment in certain Medicaid and Medicare related businesses. The notes included a feature to convert the note balance into an equity ownership in the underlying businesses.
In September 2012, the Company executed an agreement with the borrower whereby the borrower agreed to pay the Company total consideration of $50,000 for retirement of the outstanding notes and equity ownership conversion feature. Under the terms of the agreement, the borrower agreed to pay the Company $30,000 by December 1, 2012, $10,000 by September 30, 2013 and $10,000 by September 30, 2014. All outstanding balances are secured by liens on certain underlying businesses as well as guaranteed personally by the principal owner of the businesses. The $10,000 notes to be paid on or before September 30, 2013 and September 30, 2014 are non-interest bearing and, as a result, total consideration has been discounted by $2,120 to reflect imputation of interest. As a result, during the third quarter of 2012, the Company recorded a pre-tax gain of $17,880 in other income representing the fair value of the total consideration in excess of the carrying value of the loans on the Company's balance sheet.

5. Premium Deficiency Reserve

The Company periodically reviews actual and anticipated experience compared to the assumptions used to establish medical costs. The Company establishes premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs.

In October 2012, the Company notified the Kentucky Cabinet for Health and Family Services that it is exercising a contractual right that it believes allows Kentucky Spirit to terminate its Medicaid managed care contract with the Commonwealth of Kentucky effective July 5, 2013. As a result, the Company recorded a premium deficiency reserve included in Medical costs expense of $63,000 for its Kentucky contract in the quarter ended September 30, 2012. The premium deficiency reserve encompasses the contract period from October 1, 2012 through July 5, 2013.

6. Debt

Debt consists of the following:

	September 30, 2012	December 31, 2011
Senior notes, at par	$250,000	$250,000
Unamortized discount on Senior notes	(2,425)	(2,814)
Interest rate swap fair value	17,196	11,431
Senior notes, net	264,771	258,617
Revolving credit agreement	40,000	—
Mortgage notes payable	84,810	86,948
Capital leases and other	5,729	6,013

Total debt	395,310	351,578
Less current portion	(3,337)	(3,234)
Long-term debt	$391,973	$348,344

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Senior Notes

In May 2011, the Company issued non-callable $250,000 5.75% Senior Notes due June 1, 2017 ($250,000 Notes) at a discount to yield 6%. At September 30, 2012, the unamortized debt discount was $2,425. In connection with the issuance, the Company entered into an interest rate swap. Gains and losses due to changes in the fair value of the interest rate swap completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $250,000 Notes. At September 30, 2012, the fair value of the interest rate swap increased the fair value of the notes by $17,196. At September 30, 2012, the variable interest rate of the swap was 3.92%.

Revolving Credit Agreement

The Company has a $350,000 revolving credit facility due in January 2016. The revolver is unsecured and has non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt to EBITDA ratios and minimum net worth. Borrowings under the revolver bear interest based upon LIBOR rates, the Federal funds rate, or the prime rate. As of September 30, 2012, the Company had $40,000 in borrowings outstanding under the agreement, leaving availability of $310,000.

The Company has outstanding letters of credit of $35,631 as of September 30, 2012, which are not part of the revolver. The letters of credit bore interest at 1.03% as of September 30, 2012.

7. Impairment Loss

During the second quarter of 2012, the Company's subsidiary, Celtic Insurance Company, experienced a high level of medical costs for individual health policies, especially for recently issued policies related to members converted from another insurer throughout the first quarter of 2012. Additionally, in June 2012, the U.S. Supreme Court upheld the constitutionality of the Patient Protection and Affordable Care Act. The Affordable Care Act, among other things, limits the profitability of the individual health insurance business because of minimum medical loss ratios, guaranteed issue policies, and increased competition in the exchange market. As a result of these factors, the Company's expectations for future growth and profitability are lower than previous estimates. The Company conducted an impairment analysis of the identifiable intangible assets and goodwill of the Celtic reporting unit, which encompasses Celtic Insurance Company, CeltiCare Health Plan of Massachusetts, Inc., and Novasys Health, Inc. For the purpose of testing goodwill, the fair value of the Celtic reporting unit was determined using discounted expected cash flows. For the purpose of testing the customer relationship intangible, the fair value was determined using the discounted expected cash flows. The impairment analysis resulted in goodwill and intangible asset impairments of $28,033, recorded as impairment loss in the consolidated statement of operations. The impaired identifiable intangible assets of $2,340 and goodwill of $25,693 were reported under the Specialty Services segment, of which $26,589 of the impairment loss is not deductible for income tax purposes.

8. Income Tax

During the third quarter of 2012, the Company recorded a tax benefit resulting from the clarification by a state taxing authority regarding a state income tax calculation. Accordingly, during the third quarter of 2012, the Company reversed the reserve associated with the uncertain tax position and recognized a net tax benefit of $4,569.

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9. Earnings (Loss) Per Share

The following table sets forth the calculation of basic and diluted net earnings (loss) per common share:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2012	2011	2012	2011
Net earnings (loss) attributable to Centene Corporation	$3,819	$28,987	$(7,202)	$81,106
Shares used in computing per share amounts:				
Weighted average number of common shares outstanding	51,584,860	50,345,512	51,393,345	50,089,845
Common stock equivalents (as determined by applying the treasury stock method)	2,221,337	2,274,838	—	2,231,061
Weighted average number of common shares and potential dilutive common shares outstanding	53,806,197	52,620,350	51,393,345	52,320,906
Net earnings (loss) per share attributable to Centene Corporation:				
Basic earnings (loss) per common share	$0.07	$0.58	$(0.14)	$1.62
Diluted earnings (loss) per common share	$0.07	$0.55	$(0.14)	$1.55

The calculation of diluted earnings (loss) per common share for the three and nine months ended September 30, 2012 excludes the impact of 44,642 and 4,638,757 shares (before application of the treasury stock method), respectively, related to anti-dilutive stock options, restricted stock and restricted stock units. The calculation of diluted earnings per common share for the three and nine months ended September 30, 2011 excludes the impact of 69,359 and 97,004 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

10. Segment Information

Centene operates in two segments: Medicaid Managed Care and Specialty Services. The Medicaid Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene's specialty companies offering products for behavioral health, care management software, health insurance exchanges, individual health insurance, life and health management, managed vision, telehealth services, and pharmacy benefits management. The health plans in Arizona, operated by our long-term care company, and Massachusetts, operated by our individual health insurance provider, are also included in the Specialty Services segment.

Segment information for the three months ended September 30, 2012, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$1,994,867	$217,597	$—	$2,212,464
Premium and service revenues from internal customers	25,138	442,387	(467,525)	—
Total premium and service revenues	$2,020,005	$659,984	$(467,525)	$2,212,464
Earnings (loss) from operations	$(55,363)	$27,722	$—	$(27,641)

Segment information for the three months ended September 30, 2011, follows:

	Medicaid	Specialty	Eliminations	Consolidated

	Managed Care	Services		Total
Premium and service revenues from external customers	$1,080,038	$185,243	$—	$1,265,281
Premium and service revenues from internal customers	16,976	171,358	(188,334)	—
Total premium and service revenues	$1,097,014	$356,601	$(188,334)	$1,265,281
Earnings from operations	$38,387	$10,160	$—	$48,547

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Segment information for the nine months ended September 30, 2012, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$5,293,736	$643,795	$—	$5,937,531
Premium and service revenues from internal customers	62,751	1,206,293	(1,269,044)	—
Total premium and service revenues	$5,356,487	$1,850,088	$(1,269,044)	$5,937,531
Earnings (loss) from operations	$(69,846)	$29,657	$—	$(40,189)

Segment information for the nine months ended September 30, 2011, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$3,179,601	$542,857	$—	$3,722,458
Premium and service revenues from internal customers	50,020	495,829	(545,849)	—
Total premium and service revenues	$3,229,621	$1,038,686	$(545,849)	$3,722,458
Earnings from operations	$109,004	$33,943	$—	$142,947

11. Contingencies

In June 2012, a class action lawsuit was filed against the Company and certain of its officers in the United States District Court for the Eastern District of Missouri. The lawsuit alleged, on behalf of purchasers of the Company's securities from February 7, 2012 through June 8, 2012, that the Company and certain of its officers violated federal securities laws by making false or misleading statements principally concerning the Company's fiscal 2012 earnings guidance. The Company believed the case was without merit. In September 2012, the plaintiff voluntarily dismissed the action without prejudice as to all claims and defendants.

In June 2012, the Company was notified by the Ohio Department of Job and Family Services (ODJFS) that Buckeye, its Ohio subsidiary, was awarded a contract to serve Medicaid members in Ohio. The award remains subject to an ongoing legal proceeding from another managed care organization that was not awarded a contract. At September 30, 2012, the Company continued to carry goodwill and intangible assets of $42,734 associated with Buckeye pending final resolution of the award.

In addition, the Company is routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters is uncertain, the Company does not expect the results of any of these matters discussed above individually, or in the aggregate, to have a material effect on its financial position or results of operations.

12. Kentucky Contract Termination

In October 2012, the Company notified the Kentucky Cabinet for Health and Family Services that it is exercising a contractual right that it believes allows the Company to terminate its Medicaid managed care contract with the Commonwealth of Kentucky effective July 5, 2013. The Company has also filed a formal dispute with the Cabinet for damages incurred under the contract. In addition, the Company has filed a lawsuit in Franklin Circuit Court against the Commonwealth of Kentucky seeking declaratory relief as a result of the Commonwealth's failure to completely and accurately disclose material information.

During the fourth quarter of 2012 and during 2013, the Company expects to incur exit costs of approximately $5,000 to $7,000, consisting primarily of lease termination fees and employee retention and severance accruals. The exit costs will be recorded during the remaining period of the contract and subsequent wind down period and are not reflected in

the financial results as of September 30, 2012.

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ITEM 2. Management's Discussion and Analysis of Financial Condition and Results of Operations.

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing. The discussion contains forward-looking statements that involve both known and unknown risks and uncertainties, including those set forth under Part II, Item 1A. "Risk Factors" of this Form 10-Q.

OVERVIEW

During the third quarter of 2012, we recorded net earnings of $0.07 per diluted share reflecting the following:

Earnings excluding Kentucky operations	$0.78
Loss from Kentucky operations	(0.31)
Subtotal	0.47
Kentucky premium deficiency reserve	(0.69)
Gains on sales of investments	0.21
Tax benefit	0.08
Net earnings per diluted share	$0.07

During the third quarter of 2012, we recorded a $63.0 million pre-tax premium deficiency reserve for our Kentucky health plan contract covering the period from October 1, 2012 through July 5, 2013, or $0.69 per diluted share. We recorded a $17.9 million pre-tax gain on the sale of investment in a convertible note and $1.5 million in gains on the sale of investments in our Georgia health plan, or $0.21 per diluted share during the third quarter of 2012. We also recorded a $4.6 million tax benefit, or $0.08 per diluted share, associated with the clarification by a state regarding the items included in the state income tax calculation These items are discussed below under the captions "Medical Costs," "Other Income (Expense)," and "Income Tax Expense."

Key financial metrics for the third quarter of 2012 are summarized as follows:

- Quarter-end at-risk managed care membership of 2,503,000, an increase of 887,300 members, or 55% year over year.
- Premium and service revenues of $2.2 billion, representing 75% growth year over year.
- Health Benefits Ratio of 93.3%, compared to 85.0% in 2011. Excluding the impact of our Kentucky operations, the HBR was 88.7% for the third quarter of 2012.
- General and Administrative expense ratio of 8.2%, compared to 11.3% in 2011.
- Operating cash flow of $317.2 million for the third quarter of 2012.

The following items contributed to our revenue and membership growth over the last year:

- Arizona. In October 2011, Bridgeway Health Solutions began operating under an expanded contract to deliver long-term care services in three geographic service areas of Arizona.
- Illinois. In May 2011, our subsidiary, IlliniCare Health Plan, began providing managed care services for older adults and adults with disabilities under the Integrated Care Program in six counties.
- Kentucky. In November 2011, our subsidiary, Kentucky Spirit Health Plan, began providing managed care services under a contract with the Kentucky Finance and Administration Cabinet to serve Medicaid beneficiaries.
- Louisiana. In February 2012, our joint venture subsidiary, Louisiana Healthcare Connections (LHC), began operating under a new contract in Louisiana to provide healthcare services to Medicaid enrollees participating in the Bayou Health program. LHC completed its three-phase membership roll-out for the three geographical service areas during the second quarter of 2012. In addition, Nurtur, our subsidiary which provides life, health and wellness programs, contracted to provide disease management services for state employees in Louisiana for the 2012 calendar year.
- Missouri. In July 2012, our subsidiary, Home State Health Plan, began operating under a new contract with the Office of Administration for Missouri to serve Medicaid beneficiaries in the Eastern, Central, and Western Managed Care Regions of the state.
- Ohio. In October 2011, Buckeye Community Health Plan, or Buckeye, began operating under an amended contract with the Ohio Department of Job and Family Services which includes the management of the pharmacy benefits for Buckeye's members.

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- Texas. In March 2012, the Company began operating under contracts in Texas that expanded its operations through new service areas including the 10 county Hidalgo Service Area and the Medicaid Rural Service Areas of West Texas, Central Texas and North-East Texas, as well as the addition of STAR+PLUS in the Lubbock Service Area. The expansion also added the management of outpatient pharmacy benefits in all service areas and products, as well as inpatient facility services for the STAR+PLUS program.

- Washington. In July 2012, we began operating under a new contract with the Washington Health Care Authority to serve Medicaid beneficiaries in the state, initially operating as Coordinated Care.

We expect the following items to contribute to our future growth potential:

- We expect to realize the continued benefit of business commenced during 2011 in Arizona, Illinois, Louisiana, Texas and Ohio as discussed above.
- In August 2012, we were notified by the Ohio Department of Job and Family Services (ODJFS) that Buckeye Community Health Plan (Buckeye), our Ohio subsidiary, was selected to serve Medicaid members in a dual-eligible demonstration program in three of Ohio's pre-determined seven regions: Northeast (Cleveland), Northwest (Toledo) and West Central (Dayton). This three-year program, which is part of the state of Ohio's Integrated Care Delivery System (ICDS) expansion, will serve those who have both Medicare and Medicaid eligibility. Enrollment is expected to begin in the second half of 2013.
- In June 2012, we were notified by the ODJFS that Buckeye, our Ohio subsidiary, was selected to be awarded a new and expanded contract to serve Medicaid members in Ohio. Under the new state contract, Buckeye will operate statewide through Ohio's three newly aligned regions (West, Central/Southeast, and Northeast). The award remains subject to an ongoing legal proceeding from another managed care organization that was not awarded a contract. At September 30, 2012, we continued to carry goodwill and intangible assets of $42.7 million associated with Buckeye pending final resolution of the award. Enrollment is expected to begin in July 2013.
- In June 2012, our Kansas subsidiary, Sunflower State Health Plan, was awarded a statewide contract to serve members in the state's KanCare program, which includes TANF, ABD non-duals, long-term care and CHIP beneficiaries. Operations are expected to commence in the first quarter of 2013.
- In May 2012, we announced the Governor and Executive Council of New Hampshire had given approval for the Department of Health and Human Services to contract with our subsidiary, Granite State Health Plan, to serve Medicaid beneficiaries in New Hampshire. Operations are currently expected to commence in the first half of 2013.
- In October 2012, we announced that our subsidiary, Kentucky Spirit Health Plan (Kentucky Spirit), notified the Cabinet for Health and Family Services that it is exercising a contractual right that it believes allows Kentucky Spirit to terminate its Medicaid managed care contract with the Commonwealth of Kentucky effective July 5, 2013. Kentucky Spirit has also filed a formal dispute with the Cabinet for damages incurred under the contract. In addition, we have filed a lawsuit in Franklin Circuit Court against the Commonwealth of Kentucky seeking declaratory relief as a result of the Commonwealth's failure to completely and accurately disclose material information.

MEMBERSHIP

From September 30, 2011 to September 30, 2012, we increased our at-risk managed care membership by 887,300, or 54.9%. The following table sets forth our membership by state for our managed care organizations:

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	September 30, 2012	2011	December 31, 2011
Arizona	23,800	22,800	23,700
Florida	209,600	188,600	198,300
Georgia	312,400	298,000	298,200
Illinois	17,900	13,600	16,300
Indiana	205,400	205,300	206,900
Kentucky	145,400	—	180,700
Louisiana	167,200	—	—
Massachusetts	28,000	34,700	35,700
Mississippi	30,600	30,600	31,600
Missouri	53,900	—	—
Ohio	173,800	162,200	159,900
South Carolina	89,400	86,500	82,900
Texas	930,700	494,500	503,800
Washington	42,000	—	—
Wisconsin	72,900	78,900	78,000
Total at-risk membership	2,503,000	1,615,700	1,816,000
Non-risk membership	—	10,600	4,900
Total	2,503,000	1,626,300	1,820,900

The following table sets forth our membership by line of business:

	September 30, 2012	2011	December 31, 2011
Medicaid	1,939,400	1,189,900	1,336,800
CHIP & Foster Care	229,600	210,600	213,900
ABD & Medicare	289,800	171,700	218,000
Hybrid Programs	35,700	38,400	40,500
Long-term Care	8,500	5,100	6,800
Total at-risk membership	2,503,000	1,615,700	1,816,000
Non-risk membership	—	10,600	4,900
Total	2,503,000	1,626,300	1,820,900

The following table identifies the Company's dual eligible membership by line of business. The membership tables above include these members.

	September 30, 2012	2011	December 31, 2011
ABD	76,900	34,000	45,400
Long-term Care	7,800	4,700	6,200
Medicare	4,000	3,100	3,200
Total	88,700	41,800	54,800

The following table provides supplemental information of other membership categories:

	September 30, 2012	2011	December 31, 2011
Cenpatico Behavioral Health:			
Arizona	162,000	175,500	168,900
Kansas	48,500	45,600	46,200

Cenpatico Behavioral Health members in Kansas will begin receiving benefits under the previously announced statewide contract to serve members in the state's KanCare program, estimated to commence in the first quarter of 2013.

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RESULTS OF OPERATIONS

The following discussion and analysis is based on our consolidated statements of operations, which reflect our results of operations for the three and nine months ended September 30, 2012 and 2011, prepared in accordance with generally accepted accounting principles in the United States.

Summarized comparative financial data for the three and nine months ended September 30, 2012 and 2011 is as follows ($ in millions):

	Three Months Ended September 30,			Nine Months Ended September 30,		
	2012	2011	% Change 2011-2012	2012	2011	% Change 2011-2012
Premium	$2,184.1	$1,239.5	76.2 %	$5,853.5	$3,640.8	60.8 %
Service	28.4	25.8	10.0 %	84.0	81.6	3.0 %
Premium and service revenues	2,212.5	1,265.3	74.9 %	5,937.5	3,722.4	59.5 %
Premium tax	235.6	36.8	541.2 %	333.5	111.0	200.6 %
Total revenues	2,448.1	1,302.1	88.0 %	6,271.0	3,833.4	63.6 %
Medical costs	2,037.0	1,053.3	93.4 %	5,370.1	3,091.0	73.7 %
Cost of services	21.7	20.2	7.5 %	66.9	60.7	10.2 %
General and administrative expenses	181.1	143.0	26.7 %	512.3	427.1	20.0 %
Premium tax expense	235.9	37.0	537.6 %	333.9	111.7	199.0 %
Impairment loss	—	—	— %	28.0	—	— %
Earnings from operations	(27.6)	48.6	(156.9)%	(40.2)	142.9	(128.1)%
Investment and other income, net	18.4	(2.0)	(1,080.7)%	18.2	(14.6)	(224.3)%
Earnings (loss) from operations, before income tax expense	(9.2)	46.6	(119.8)%	(22.0)	128.3	(117.1)%
Income tax expense (benefit)	(9.5)	18.4	(151.7)%	(6.1)	49.2	(112.3)%
Net earnings	0.3	28.2	(99.0)%	(15.9)	79.1	(120.1)%
Noncontrolling interest	(3.5)	(0.8)	355.3 %	(8.7)	(2.0)	335.1 %
Net earnings (loss) attributable to Centene Corporation	$3.8	$29.0	(86.8)%	$(7.2)	$81.1	(108.9)%
Diluted earnings (loss) per common share attributable to Centene Corporation	$0.07	$0.55	(87.3)%	$(0.14)	$1.55	(109.0)%

Three Months Ended September 30, 2012 Compared to Three Months Ended September 30, 2011

Revenues and Revenue Recognition

Premium and service revenues increased 74.9% in the three months ended September 30, 2012 over the corresponding period in 2011 primarily as a result of the additions between years of the Texas and Arizona expansions, pharmacy carve-ins in Texas and Ohio, Kentucky, Louisiana, Missouri and Washington contracts, and membership growth.

One of our states maintains a reconciliation process associated with membership eligibility and has continued to reconcile membership from previous periods. The amount of any reduction to revenue related to this review is subject to consideration of rate adequacy calculations, as part of actuarially soundness standards, for the appropriate periods. We have estimated the revenue impact related to reconciliation adjustments to the retroactive eligibility reductions due to the state and have adjusted our accrual in our consolidated financial statements. There can be no assurance that future adjustment of amounts related to membership reconciliations will not have a material adverse effect on the Company.

Operating Expenses

Medical Costs

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately estimate costs incurred. The Health Benefits Ratio, or HBR, represents medical costs as a percentage of premium

revenues (excluding premium taxes) and reflects the direct relationship between the premium received and the medical services provided. The table below depicts the HBR for our membership by member category for the three months ended September 30:

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	2012		2011	
Medicaid and CHIP	91.8	%	81.5	%
ABD and Medicare	97.3		92.0	
Specialty Services	89.5		87.9	
Total	93.3		85.0	

The consolidated HBR for the three months ended September 30, 2012 was 93.3% compared to 85.0% in the same period in 2011. The increase compared to last year primarily reflects the recognition of a $63.0 million premium deficiency reserve for our Kentucky contract as well as increased medical costs in Kentucky. Excluding our Kentucky health plan operations, the third quarter 2012 HBR was 88.7%.

In October 2012, we notified the Kentucky Cabinet for Health and Family Services that we are exercising a contractual right that we believe allows our Kentucky Spirit Health Plan to terminate its Medicaid managed care contract with the Commonwealth of Kentucky effective July 5, 2013. As a result, we recorded a premium deficiency reserve included in Medical costs expense of $63.0 million for the Kentucky Spirit Health Plan contract in the quarter ended September 30, 2012. This premium deficiency reserve encompasses the contract period from October 1, 2012 through July 5, 2013.

General & Administrative Expenses

General and administrative expenses, or G&A, increased by $38.1 million in the three months ended September 30, 2012, compared to the corresponding period in 2011. This was primarily due to expenses for additional staff and facilities to support our membership growth, partially offset by a reduction in performance based compensation expense in 2012.

The consolidated G&A expense ratio for the three months ended September 30, 2012, and 2011 was 8.2%, and 11.3%, respectively. The year over year decrease reflects the leveraging of expenses over higher revenues and a reduction in performance based compensation expense which lowered the ratio by 50 basis points.

Other Income (Expense)

The following table summarizes the components of other income (expense) for the three months ended September 30, ($ in millions):

	2012	2011
Investment income	$3.9	$2.5
Gain on sale of investments	1.5	0.1
Gain on sale of investment in convertible note	17.9	—
Interest expense	(4.9)	(4.6)
Other income (expense), net	$18.4	$(2.0)

Investment income. The increase in investment income in 2012 reflects an increase in investment balances over 2011.

Gain on sale of investments. During the third quarter of 2012, we recognized $1.5 million in net gains primarily as a result of the liquidation of $75.5 million of investments held by the Georgia health plan in order to meet short-term liquidity needs due to the delays in premium receipts.

Gain on sale of investment in convertible note. Between July 2008 and October 2011, we made an investment of $30.0 million in secured notes receivable to a third party as part of an investment in certain Medicaid and Medicare related businesses. The notes included a feature to convert the note balance into an equity ownership in the underlying businesses. In September 2012, we executed an agreement with the borrower whereby the borrower agreed to pay us total consideration of $50.0 million for retirement of the outstanding notes and equity ownership conversion feature. As a result, during the third quarter of 2012, we recorded a pre-tax gain of $17.9 million in other income representing the fair value of the total consideration in excess of the carrying value of the loans on the balance sheet.

Interest expense. Interest expense was relatively flat in 2012 compared to 2011, reflecting a consistent interest rate on our Senior Notes.

Income Tax Expense

During the three months ended September 30, 2012, we recognized a tax benefit of $9.5 million compared to tax expense of $18.5 million in the corresponding period in 2011. During the third quarter of 2012, we recorded a tax benefit resulting from the clarification by a state taxing authority regarding a state income tax calculation.

Accordingly, during the third quarter of 2012, we reversed the reserve associated with the uncertain tax position and recognized a net tax benefit of $4.6 million, or $0.08 per share. We expect the state income tax determination to have a favorable impact of approximately $2.5 million in 2013.

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Segment Results

The following table summarizes our operating results by segment for the three months ended September 30, (in millions):

	2012	2011	% Change 2011-2012	
Premium and Service Revenues				
Medicaid Managed Care	$2,020.0	$1,097.0	84.1	%
Specialty Services	660.0	356.6	85.1	%
Eliminations	(467.5)	(188.3)	148.2	%
Consolidated Total	$2,212.5	$1,265.3	74.9	%
Earnings (Loss) from Operations				
Medicaid Managed Care	$(55.3)	$38.4	(244.2)	%
Specialty Services	27.7	10.1	172.9	%
Consolidated Total	$(27.6)	$48.5	(156.9)	%

Medicaid Managed Care

Premium and service revenues increased 84.1% in the three months ended September 30, 2012, due to the addition of our Kentucky, Louisiana, Missouri and Washington contracts, Texas expansion, pharmacy carve-ins in Texas and Ohio, and membership growth. Earnings from operations decreased $93.7 million in the three months ended September 30, 2012, primarily due to the $63.0 million premium deficiency reserve recorded for our Kentucky health plan contract as well as an operating loss of $28.5 million in our Kentucky health plan.

Specialty Services

Premium and service revenues increased 85.1% in the three months ended September 30, 2012, due to the carve-in of pharmacy services in Texas and Ohio, growth in our Medicaid segment and the associated specialty services provided to this increased membership as well as the Arizona expansion. Earnings from operations increased $17.6 million in the three months ended September 30, 2012, reflecting growth in our pharmacy business and the associated specialty services provided to our increased Medicaid membership.

Nine Months Ended September 30, 2012 Compared to Nine Months Ended September 30, 2011

Premium and Service Revenues

Premium and service revenues increased 59.5% in the nine months ended September 30, 2012 over the corresponding period in 2011 as a result of the additions between years of our Illinois, Kentucky, Louisiana, Missouri and Washington contracts, Texas and Arizona expansions, pharmacy carve-ins in Texas and Ohio, and membership growth. During the nine months ended September 30, 2012, we received premium rate adjustments which yielded a net 2.0% composite change across all of our markets.

Operating Expenses

Medical Costs

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately estimate costs incurred. The Health Benefits Ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding premium taxes) and reflects the direct relationship between the premium received and the medical services provided. The table below depicts the HBR for our membership by member category for the nine months ended September 30:

	2012		2011	
Medicaid and CHIP	90.8	%	82.3	%
ABD and Medicare	93.4		90.3	
Specialty Services	92.5		87.4	
Total	91.7		84.9	

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The consolidated HBR for the nine months ended September 30, 2012, of 91.7% was an increase of 680 basis points over the comparable period in 2011. The increase compared to last year primarily reflects (1) the recognition of a $63.0 million premium deficiency reserve for our Kentucky contract as well as increased medical costs in Kentucky, (2) increased medical costs in the March 1, 2012 expansion areas in Texas during the second quarter of 2012 , and (3) a high level of medical costs during the second quarter of 2012 in the individual health business, especially for recently issued polices related to members converted in the first quarter of 2012. Excluding our Kentucky operations, the HBR for the nine months ended September 30, 2012, was 89.1%.

General & Administrative Expenses

General and administrative expenses, or G&A, increased by $85.3 million in the nine months ended September 30, 2012, compared to the corresponding period in 2011. This was primarily due to expenses for additional staff and facilities to support our membership growth, partially offset by a reduction in performance based compensation expense in 2012.

The consolidated G&A expense ratio for the nine months ended September 30, 2012, and 2011 was 8.6% and 11.5% respectively. The year over year decrease in the G&A expense ratio reflects the leveraging of expenses over higher revenues in 2012 and a reduction in performance based compensation expense in 2012 which lowered the G&A expense ratio by 50 basis points.

Other Income (Expense)

The following table summarizes the components of other income (expense) for the nine months ended September 30, ($ in millions):

	2012	2011
Investment income	$13.2	$9.2
Gain on sale of investments	1.5	0.2
Gain on sale of investment in convertible note	17.9	—
Debt extinguishment costs	—	(8.5)
Interest expense	(14.4)	(15.5)
Other income (expense), net	$18.2	$(14.6)

Investment income. The increase in investment income in 2012 reflects an increase in investment balances over 2011.

Gain on sale of investments. During the third quarter of 2012, we recognized $1.5 million in net gains primarily as a result of the liquidation of $75.5 million of investments held by the Georgia health plan in order to meet short-term liquidity needs due to the delays in premium receipts.

Gain on sale of investment in convertible note. Between July 2008 and October 2011, we made an investment of $30.0 million in secured notes receivable to a third party as part of an investment in certain Medicaid and Medicare related businesses. The notes included a feature to convert the note balance into an equity ownership in the underlying businesses. In September 2012, we executed an agreement with the borrower whereby the borrower agreed to pay us total consideration of $50.0 million for retirement of the outstanding notes and equity ownership conversion feature. As a result, during the third quarter of 2012, we recorded a pre-tax gain of $17.9 million in other income representing the fair value of the total consideration in excess of the carrying value of the loans on the balance sheet.

Interest expense. Interest expense decreased during the nine months ended September 30, 2012 by $1.1 million reflecting the refinancing of our Senior Notes and execution of the associated interest rate swap agreement in 2011, as well as a reduction in borrowings on our revolver over the prior period.

Income Tax Expense

Excluding the effects of noncontrolling interests, our effective tax rate for the nine months ended September 30, 2012 was a tax benefit of 45.7% compared to tax expense of 37.8% in the corresponding period in 2011. The tax benefit for the nine months ended September 30, 2012 primarily resulted from decreased earnings in 2012 and a tax benefit resulting from the clarification by a state taxing authority regarding a state income tax calculation. Accordingly, during the third quarter of 2012, we reversed the reserve associated with the uncertain tax position and recognized a net tax benefit of $4.6 million. These tax benefits were partially offset by Celtic's non-deductible goodwill impairment recorded in the second quarter of 2012.

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Impairment Loss

During the second quarter of 2012, our subsidiary, Celtic Insurance Company, experienced a high level of medical costs for individual health policies, especially for recently issued policies related to members converted from another insurer throughout the first quarter of 2012. Additionally, in June 2012, the U.S. Supreme Court upheld the constitutionality of the Patient Protection and Affordable Care Act. The Affordable Care Act, among other things, limits the profitability of the individual health insurance business because of minimum medical loss ratios, guaranteed issue policies, and increased competition in the exchange market. As a result of these factors, our expectations for future growth and profitability are lower than previous estimates. We conducted an impairment analysis of the identifiable intangible assets and goodwill of the Celtic reporting unit, which encompasses Celtic Insurance Company, CeltiCare Health Plan of Massachusetts, Inc., and Novasys Health, Inc. The impairment analysis resulted in goodwill and intangible asset impairments of $28.0 million, recorded as impairment loss in the consolidated statement of operations. The impaired identifiable intangible assets of $2.3 million and goodwill of $25.7 million were reported under the Specialty Services segment, of which $26.6 million of the impairment loss is not deductible for income tax purposes.

Segment Results

The following table summarizes our operating results by segment for the nine months ended September 30, (in millions):

	2012	2011	% Change 2011-2012
Premium and Service Revenues			
Medicaid Managed Care	$5,356.4	$3,229.6	65.9 %
Specialty Services	1,850.1	1,038.7	78.1 %
Eliminations	(1,269.0)	(545.8)	132.5 %
Consolidated Total	$5,937.5	$3,722.5	59.5 %
Earnings (Loss) from Operations			
Medicaid Managed Care	$(69.8)	$109.0	(164.1)%
Specialty Services	29.6	33.9	(12.6)%
Consolidated Total	$(40.2)	$142.9	(128.1)%

Medicaid Managed Care

Premium and service revenues increased 65.9% in the nine months ended September 30, 2012, due to the addition of our Illinois, Kentucky, Louisiana, Missouri and Washington contracts, Texas expansion, pharmacy carve-ins in Texas and Ohio, and membership growth. Earnings from operations decreased $178.8 million in the nine months ended September 30, 2012, primarily due to higher medical costs in our Texas health plan, a premium deficiency reserve of $63.0 million recorded for our Kentucky health plan contract and an operating loss of $65.9 million in our Kentucky health plan.

Specialty Services

Premium and service revenues increased 78.1% in the nine months ended September 30, 2012, due to the carve-in of pharmacy services in Texas and Ohio, growth in our Medicaid segment and the associated specialty services provided to this increased membership as well as the Arizona expansion. Earnings from operations decreased $4.3 million in the nine months ended September 30, 2012, reflecting the impairment loss of $28.0 million recorded in the second quarter of 2012 and a high level of medical costs in Celtic Insurance Company, especially for recently issued polices related to members converted in the first quarter of 2012, partially offset by growth in our pharmacy business and the associated specialty services provided to our increased Medicaid membership.

Earnings (Loss) Per Share and Shares Outstanding

Our earnings (loss) per share calculation for the nine months ended September 30, 2012 reflects lower diluted weighted average shares outstanding resulting from the exclusion of the effect of outstanding stock awards which would be anti-dilutive to earnings per share.

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LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows for the nine months ended September 30, 2012 and 2011, used in the discussion of liquidity and capital resources ($ in millions).

	Nine Months Ended September 30,	
	2012	2011
Net cash provided by operating activities	$307.3	$89.7
Net cash used in investing activities	(138.6)	(81.2)
Net cash provided by financing activities	54.2	9.0
Net increase in cash and cash equivalents	$222.9	$17.5

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our revolving credit facility. Operating activities provided cash of $307.3 million in the nine months ended September 30, 2012, compared to $89.7 million in the comparable period in 2011. The cash provided by operations was primarily related to an increase in medical claims liabilities related to the start up of our Louisiana, Missouri and Washington plans and the expansion of our Texas health plan as well as pre-payment of premiums in two of our states.

Cash flows from operations in each year were impacted by the timing of payments we receive from our states. States may prepay the following month premium payment, which we record as unearned revenue, or they may delay our premium payment, which we record as a receivable. We typically receive capitation payments monthly, however the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period. At June 30, 2012, receivables from the State of Georgia totaled approximately $221 million. As a result of capitation payments made during the third quarter 2012, receivables from the State of Georgia were reduced to approximately $106 million at September 30, 2012. The table below details the impact to cash flows from operations from the timing of payments from our states ($ in millions).

	Nine Months Ended September 30,	
	2012	2011
Premium and related receivables	$(139.4)	$(13.3)
Unearned revenue	122.1	(65.2)
Net decrease in operating cash flow	$(17.3)	$(78.5)

Cash Flows Used in Investing Activities

Investing activities used cash of $138.6 million in the nine months ended September 30, 2012 and $81.2 million in the comparable period in 2011. Cash flows from investing activities in 2012 and 2011 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long-term investments, and capital expenditures. As of September 30, 2012, our investment portfolio consisted primarily of fixed-income securities with an average duration of 2.2 years. We had unregulated cash and investments of $36.0 million at September 30, 2012, compared to $38.3 million at December 31, 2011.

We spent $70.6 million and $56.9 million in the nine months ended September 30, 2012 and 2011, respectively, on capital expenditures for system enhancements, a new datacenter and market expansions including $20.9 million for land in close proximity to our corporate headquarters to support future growth. We anticipate spending approximately $15 million additional on capital expenditures in 2012 primarily associated with system enhancements and market expansions.

Cash Flows Provided by Financing Activities

Our financing activities provided cash of $54.2 million in the nine months ended September 30, 2012 compared to $9.0 million in the comparable period in 2011. During 2012, our financing activities primarily related to borrowings under our revolving credit facility.

We had outstanding letters of credit of $35.6 million as of September 30, 2012, which are not part of our revolving credit facility. The letters of credit bore interest at 1.03% as of September 30, 2012. We expect the letters of credit to be reduced by $23.3 million during the fourth quarter 2012.

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We expect to make capital contributions of approximately $200 million during the fourth quarter of 2012 associated with our growth. These capital contributions are expected to be funded by unregulated cash flow generation in the fourth quarter of 2012 and borrowings on our revolving credit facility.

At September 30, 2012, we had working capital, defined as current assets less current liabilities, of $96.4 million, as compared to $102.4 million at December 31, 2011. We manage our short-term and long-term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short-term requirements as needed.

At September 30, 2012, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 29.2%, compared to 27.3% at December 31, 2011. Excluding the $76.0 million non-recourse mortgage note, our debt to capital ratio is 25.0%, compared to 22.6% at December 31, 2011. We utilize the debt to capital ratio as a measure, among others, of our leverage and financial flexibility.

Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our credit facility will be sufficient to finance our general operations and capital expenditures for at least 12 months from the date of this filing.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

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

Our subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of September 30, 2012, our subsidiaries had aggregate statutory capital and surplus of $865.5 million, compared with the required minimum aggregate statutory capital and surplus requirements of $552.4 million. Excluding our Kentucky health plan, we estimate our Risk Based Capital, or RBC, percentage to be in excess of 350% of the Authorized Control Level.

The National Association of Insurance Commissioners has adopted rules which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of September 30, 2012, each of our health plans was in compliance with the risk-based capital requirements enacted in those states.

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ITEM 3. Quantitative and Qualitative Disclosures About Market Risk.

INVESTMENTS AND DEBT

As of September 30, 2012, we had short-term investments of $139.9 million and long-term investments of $593.2 million, including restricted deposits of $33.5 million. The short-term investments generally consist of highly liquid securities with maturities between three and 12 months. The long-term investments consist of municipal, corporate and U.S. Treasury securities, government sponsored obligations, life insurance contracts, asset backed securities and equity securities and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long-term regardless of the contractual maturity date. Our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at September 30, 2012, the fair value of our fixed income investments would decrease by approximately $13.0 million. Declines in interest rates over time will reduce our investment income.

We entered into interest rate swap agreements with creditworthy financial institutions to manage the impact of market interest rates on interest expense. Our swap agreements convert a portion of our interest expense from fixed to variable rates to better match the impact of changes in market rates on our variable rate cash equivalent investments. As a result, the fair value of our $250 million Senior Note debt varies with market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at September 30, 2012, the fair value of our debt would decrease by approximately $11.9 million. An increase in interest rates decreases the fair value of the debt and conversely, a decrease in interest rates increases the value.

For a discussion of the interest rate risk that our investments are subject to, see "Risk Factors–Risks Related to Our Business–Our investment portfolio may suffer losses from reductions in market interest rates and changes in market conditions which could materially and adversely affect our results of operations or liquidity."

INFLATION

The inflation rate for medical care costs has been higher than the inflation rate for all items. We use various strategies to mitigate the negative effects of healthcare cost inflation. Specifically, our health plans try to control medical and hospital costs through our state savings initiatives and contracts with independent providers of healthcare services. Through these contracted care providers, our health plans emphasize preventive healthcare and appropriate use of specialty and hospital services. Additionally, our contracts with states require actuarially sound premiums that include health care cost trend.

While we currently believe our strategies to mitigate healthcare cost inflation will continue to be successful, competitive pressures, new healthcare and pharmaceutical product introductions, demands from healthcare providers and customers, applicable regulations or other factors may affect our ability to control the impact of healthcare cost increases.

ITEM 4. Controls and Procedures.

Evaluation of Disclosure Controls and Procedures - We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Form 10-Q, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of September 30, 2012. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of September 30, 2012.

Changes in Internal Control Over Financial Reporting - No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the quarter ended September 30, 2012 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

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PART II
OTHER INFORMATION

ITEM 1. Legal Proceedings.

In June 2012, a class action lawsuit was filed against the Company and certain of its officers in the United States District Court for the Eastern District of Missouri. The lawsuit alleged, on behalf of purchasers of the Company's securities from February 7, 2012 through June 8, 2012, that the Company and certain of its officers violated federal securities laws by making false or misleading statements principally concerning the Company's fiscal 2012 earnings guidance. The Company believed the case was without merit. In September 2012, the plaintiff voluntarily dismissed the action without prejudice as to all claims and defendants.
In October 2012, the Company notified the Kentucky Cabinet for Health and Family Services that it is exercising a contractual right that it believes allows the Company to terminate its Medicaid managed care contract with the Commonwealth of Kentucky effective July 5, 2013. The Company has also filed a formal dispute with the Cabinet for damages incurred under the contract. In addition, the Company has filed a lawsuit in Franklin Circuit Court against the Commonwealth of Kentucky seeking declaratory relief as a result of the Commonwealth's failure to completely and accurately disclose material information.

ITEM 1A. Risk Factors.

FACTORS THAT MAY AFFECT FUTURE RESULTS AND THE
TRADING PRICE OF OUR COMMON STOCK

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

Risks Related to Being a Regulated Entity

Reduction in Medicaid, CHIP and ABD funding could substantially reduce our profitability.

Most of our revenues come from Medicaid, CHIP and ABD premiums. The base premium rate paid by each state differs, depending on a combination of factors such as defined upper payment limits, a member’s health status, age, gender, county or region, benefit mix and member eligibility categories. Since Medicaid was created in 1965, the federal government and the states have shared the costs, with the federal share currently averaging around 57%. Future levels of Medicaid, CHIP and ABD funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints.

In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act collectively referred to as the Affordable Care Act (ACA), were enacted. While the constitutionality of the ACA was subsequently challenged in a number of legal actions, in June 2012, the Supreme Court upheld the constitutionality of the ACA, with one limited exception relating to the Medicaid expansion provision. The Court held that states could not be required to expand Medicaid or risk losing all federal money for their existing Medicaid programs. Under the ACA, Medicaid coverage will be expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level beginning January 1, 2014. The federal government will pay

the entire costs for Medicaid coverage for newly eligible beneficiaries for 3 years, from 2014 through 2016. In 2017, the federal share declines to 95%; in 2018 it is 94%; in 2019 it is 93%; and it will be 90% in 2020 and subsequent years. States may delay Medicaid expansion after 2014 but the federal payment rates will be less. It is unknown as to what states will expand their Medicaid programs although certain states, including Florida, Louisiana, and Texas, have indicated that they will not do so.

Although states are currently required by law to maintain current Medicaid eligibility standards until at least 2014, at least one state has filed a lawsuit challenging the constitutionality of the “maintenance of effort” (MOE) provision based on the Supreme Court’s decision. States may also seek to reduce reimbursement or benefits to enable them to afford to maintain their eligibility levels.

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States periodically consider reducing or reallocating the amount of money they spend for Medicaid, CHIP, Foster Care and ABD. The current adverse economic conditions have, and are expected to continue to, put pressures on state budgets as tax and other state revenues decrease while these eligible populations increase, creating more need for funding. We anticipate this will require government agencies with whom we contract to find funding alternatives, which may result in reductions in funding for current programs and program expansions, contraction of covered benefits, limited or no premium rate increases or premium decreases. In recent years, the majority of states have implemented measures to restrict Medicaid, CHIP, Foster Care and ABD costs and eligibility. If any state in which we operate were to decrease premiums paid to us, or pay us less than the amount necessary to keep pace with our cost trends, it could have a material adverse effect on our revenues and operating results.

Changes to Medicaid, CHIP, Foster Care and ABD programs could reduce the number of persons enrolled in or eligible for these programs, reduce the amount of reimbursement or payment levels, or increase our administrative or healthcare costs under these programs, all of which could have a negative impact on our business. Recent legislation generally requires that eligibility levels be maintained, but this could cause states to reduce reimbursement or reduce benefits in order to afford to maintain eligibility levels. A number of states have requested waivers to the requirements to maintain eligibility levels and legislation has been introduced that would eliminate the requirement that eligibility levels be maintained. We believe that reductions in Medicaid, CHIP, Foster Care and ABD payments could substantially reduce our profitability. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds.

If we are unable to participate in CHIP programs, our growth rate may be limited.

CHIP is a federal initiative designed to provide coverage for low-income children not otherwise covered by Medicaid or other insurance programs. The programs vary significantly from state to state. Participation in CHIP programs is an important part of our growth strategy. If states do not allow us to participate or if we fail to win bids to participate, our growth strategy may be materially and adversely affected.

If CHIP is not reauthorized or states face shortfalls, our business could suffer.

Federal support for CHIP has been authorized through 2019, with funding authorized through 2015. We cannot be certain that funding for CHIP will be reauthorized when current funding expires in 2015. Thus, we cannot predict the impact that reauthorization will have on our business.

States receive matching funds from the federal government to pay for their CHIP programs which have a per state annual cap. Because of funding caps, there is a risk that states could experience shortfalls in future years, which could have an impact on our ability to receive amounts owed to us from states in which we have CHIP contracts.

If any of our state contracts are terminated or are not renewed, our business will suffer.

We provide managed care programs and selected services to individuals receiving benefits under federal assistance programs, including Medicaid, CHIP and ABD. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. Our contracts with various states are generally intended to run for one or two years and may be extended for one or two additional years if the state or its agent elects to do so. Our current contracts are set to expire or renew between December 31, 2012 and December 31, 2016. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. For example, on April 12, 2010, the Wisconsin Department of Health Services notified us that our Wisconsin subsidiary was not awarded a Southeast Wisconsin BadgerCare Plus Managed Care contract. While we will continue to serve other regions of the state, we transitioned the affected members to other plans by November 1, 2010. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the

event of unavailability of state funds. For example, the Indiana contract under which we operate can be terminated by the State without cause. Our contracts could also be terminated if we fail to perform in accordance with the standards set by state regulatory agencies. If any of our contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, our business will suffer, and our financial position, results of operations or cash flows may be materially affected.

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Changes in government regulations designed to protect the financial interests of providers and members rather than our investors could force us to change how we operate and could harm our business.

Our business is extensively regulated by the states in which we operate and by the federal government. The applicable laws and regulations are subject to frequent change and generally are intended to benefit and protect the financial interests of health plan providers and members rather than investors. The enactment of new laws and rules or changes to existing laws and rules or the interpretation of such laws and rules could, among other things:

- force us to restructure our relationships with providers within our network;
- require us to implement additional or different programs and systems;
- mandate minimum medical expense levels as a percentage of premium revenues;
- restrict revenue and enrollment growth;
- require us to develop plans to guard against the financial insolvency of our providers;
- increase our healthcare and administrative costs;
- impose additional capital and reserve requirements; and
- increase or change our liability to members in the event of malpractice by our providers.

The ACA also requires that proposed increases of 10% or more of premiums for most individual and small group insurance health insurance plans must be approved by state or federal officials (Rate Review Program).

Regulations may decrease the profitability of our health plans.

Certain states have enacted regulations which require us to maintain a minimum health benefits ratio, or establish limits on our profitability. Other states require us to meet certain performance and quality metrics in order to receive our full contractual revenue. In certain circumstances, our plans may be required to pay a rebate to the state in the event profits exceed established levels. These regulatory requirements, changes in these requirements or the adoption of similar requirements by other regulators may limit our ability to increase our overall profits as a percentage of revenues. Most states, including but not limited to Georgia, Indiana, Texas and Wisconsin have implemented prompt-payment laws and many states are enforcing penalty provisions for failure to pay claims in a timely manner. Failure to meet these requirements can result in financial fines and penalties. In addition, states may attempt to reduce their contract premium rates if regulators perceive our health benefits ratio as too low. Any of these regulatory actions could harm our financial position, results of operations or cash flows. Certain states also impose marketing restrictions on us which may constrain our membership growth and our ability to increase our revenues.

If we fail to comply with Medicare laws and regulation, our growth rate could be limited.

We feel there are potential growth opportunities in dual eligible markets to fully integrate care for dual eligible beneficiaries who are enrolled in both Medicaid and Medicare. The dual eligible population represents a disproportionate amount of state and federal health care spending yet less than 15 percent of dual eligibles are in comprehensive, managed care. As a result, states and the federal government have put dual eligibles on the fast track to managed care and dual eligibles are an important part of our growth strategy.

Although we believe that we substantially comply with all existing Medicare statutes and regulations applicable to our business, different interpretations and enforcement policies of these laws and regulations could subject our current practices to allegations of impropriety or illegality or could require us to make significant changes to our operations. If we fail to comply with existing or future applicable Medicare laws and regulations, states may not allow us to continue to participate in dual eligible demonstration programs or we may fail to win bids to participate in such programs, and our growth strategy may be materially and adversely affected.

We face periodic reviews, audits and investigations under our contracts with state and federal government agencies, and these audits could have adverse findings, which may negatively impact our business.

We contract with various state and federal governmental agencies to provide managed healthcare services. Pursuant to these contracts, we are subject to various reviews, audits and investigations to verify our compliance with the contracts and applicable laws and regulations. Any adverse review, audit or investigation could result in:

- cancellation of our contracts;
- refunding of amounts we have been paid pursuant to our contracts;
- imposition of fines, penalties and other sanctions on us;

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- loss of our right to participate in various markets;
- increased difficulty in selling our products and services; or
- loss of one or more of our licenses.

Failure to comply with government regulations could subject us to civil and criminal penalties.

Federal and state governments have enacted fraud and abuse laws and other laws to protect patients' privacy and access to healthcare. In some states, we may be subject to regulation by more than one governmental authority, which may impose overlapping or inconsistent regulations. Violation of these and other laws or regulations governing our operations or the operations of our providers could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide services, the suspension or revocation of our licenses or our exclusion from participating in the Medicaid, CHIP, Foster Care and ABD programs. If we were to become subject to these penalties or exclusions as the result of our actions or omissions or our inability to monitor the compliance of our providers, it would negatively affect our ability to operate our business.

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

We may incur significant costs as a result of compliance with government regulations, and our management will be required to devote time to compliance.

Many aspects of our business are affected by government laws and regulations. The issuance of new regulations, or judicial or regulatory guidance regarding existing regulations, could require changes to many of the procedures we currently use to conduct our business, which may lead to additional costs that we have not yet identified. We do not know whether, or the extent to which, we will be able to recover from the states our costs of complying with these new regulations. The costs of any such future compliance efforts could have a material adverse effect on our business. We have already expended significant time, effort and financial resources to comply with the privacy and security requirements of HIPAA and will have to expend additional time and financial resources to comply with the HIPAA provisions contained in the American Recovery and Reinvestment Act of 2009 and the Patient Protection and Affordable Care Act and Health Care and Education Affordability Reconciliation Act. We cannot predict whether states will enact stricter laws governing the privacy and security of electronic health information. If any new requirements are enacted at the state or federal level, compliance would likely require additional expenditures and management time.

Changes in healthcare law and benefits may reduce our profitability.

Changes in applicable laws and regulations are continually being considered, and interpretations of existing laws and rules may also change from time to time. We are unable to predict what regulatory changes may occur or what effect any particular change may have on our business. For example, these changes could reduce the number of persons enrolled or eligible to enroll in Medicaid, reduce the reimbursement or payment levels for medical services or reduce benefits included in Medicaid coverage. We are also unable to predict whether new laws or proposals will favor or hinder the growth of managed healthcare in general.

Beginning in 2014, the ACA requires that policies of health insurance offered in individual and small group markets as well as Medicaid benchmark plans provide coverage of designated items and services known as essential health benefits. These must include at least 10 legally defined benefit categories. HHS has granted states significant flexibility in establishing what constitutes essential health benefits in their states. The diversity of essential health benefits across states will increase the complexity in managing health plans and may affect payments.

Initiatives have begun in at least 26 states to more efficiently care for people who are dually eligible for Medicare and Medicaid. As a result, hospitals are seeking higher Medicare reimbursement rates for these patients from insurers which could negatively impact profits.

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The health care reform law and the implementation of that law could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

The ACA provides comprehensive changes to the U.S. health care system, which are being phased in at various stages through 2018. The legislation imposes an annual insurance industry assessment of $8 billion starting in 2014, with increasing annual amounts thereafter. Such assessment may not be deductible for income tax purposes. If this federal premium tax is imposed as enacted, and if the cost of the federal premium tax is not included in the calculation of our rates, or if we are unable to otherwise adjust our business model to address this new tax, our results of operations, financial position and liquidity may be materially adversely affected.

There are numerous outstanding steps required to implement the legislation, including the promulgation of a substantial number of new and potentially more onerous federal regulations. Further, various health insurance reform proposals are also emerging at the state level. Because of the unsettled nature of these reforms and numerous steps required to implement them, we cannot predict what additional health insurance requirements will be implemented at the federal or state level, or the effect that any future legislation or regulation will have on our business or our growth opportunities.

Although we believe the legislation may provide us with significant opportunities to grow our business, the enacted reforms, as well as future regulations and legislative changes, may in fact have a material adverse affect on our results of operations, financial position or liquidity. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of health care reform, or do not do so as effectively as our competitors, our business may be materially adversely affected.

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

States may administer Medicaid managed care programs pursuant to demonstration programs or required waivers of federal Medicaid standards. Waivers and demonstration programs are generally approved for two year periods and can be renewed on an ongoing basis if the state applies. We have no control over this renewal process. If a state does not renew such a waiver or demonstration program or the Federal government denies a state's application for renewal, membership in our health plan in the state could decrease and our business could suffer.

Changes in federal funding mechanisms may reduce our profitability.

Changes in funding for Medicaid may affect our business. For example, on May 29, 2007, CMS issued a final rule that would reduce states' use of intergovernmental transfers for the states' share of Medicaid program funding. By restricting the use of intergovernmental transfers, this rule may restrict some states' funding for Medicaid, which could adversely affect our growth, operations and financial performance. On May 23, 2008, the United States District Court for the District of Columbia vacated the final rule as improperly promulgated. On November 30, 2010, CMS issued final regulations that remove these provisions and restore the regulatory language that was in place before the 2007 regulations were issued. While this rule has been removed, we cannot predict whether another similar rule or any other rule that changes funding mechanisms will be promulgated, and if any are, what impact they will have on our business.

Legislative changes in the Medicare program may also affect our business. For example, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 revised cost-sharing requirements for some beneficiaries and required states to reimburse the federal Medicare program for costs of prescription drug coverage provided to beneficiaries who are enrolled simultaneously in both the Medicaid and Medicare programs.

Medicaid spending by the federal government could be decreased as part of the spending cuts associated with the recent increase of the debt ceiling.

The Sequestration Transparency Act of 2012 (P.L. 112-155) requires President Obama to submit to Congress a report on the potential sequestration triggered by the failure of the Joint Selective Committee on Deficit Reduction to propose, and Congress to enact, a plan to reduce the deficit by $1.2 trillion, as required by the Budget Control Act of 2011. Under the sequestration, automatic spending cuts would become effective beginning January 2, 2013. This would result in cuts of 2% ($11.1 billion) to Medicare. However, Medicaid is exempt from the automatic spending cuts.

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We cannot predict whether Congress will take any action to change the automatic spending cuts. Further, we cannot predict how states will react to any changes that occur at the federal level.

If state regulatory agencies require a statutory capital level higher than the state regulations, we may be required to make additional capital contributions.

Our operations are conducted through our wholly owned subsidiaries, which include health maintenance organizations, or HMOs, and managed care organizations, or MCOs. HMOs and MCOs are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Additionally, state regulatory agencies may require, at their discretion, individual HMOs to maintain statutory capital levels higher than the state regulations. If this were to occur to one of our subsidiaries, we may be required to make additional capital contributions to the affected subsidiary. Any additional capital contribution made to one of the affected subsidiaries could have a material adverse effect on our liquidity and our ability to grow.

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

We principally operate through our health plan subsidiaries. If funds normally available to us become limited in the future, we may need to rely on dividends and distributions from our subsidiaries to fund our operations. These subsidiaries are subject to regulations that limit the amount of dividends and distributions that can be paid to us without prior approval of, or notification to, state regulators. If these regulators were to deny our subsidiaries' request to pay dividends to us, the funds available to us would be limited, which could harm our ability to implement our business strategy.

Risks Related to Our Business

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

Our health plans rely on other state-operated systems or sub-contractors to qualify, solicit, educate and assign eligible members into the health plans. The effectiveness of these state operations and sub-contractors can have a material effect on a health plan's enrollment in a particular month or over an extended period. When a state implements new programs to determine eligibility, new processes to assign or enroll eligible members into health plans, or chooses new contractors, there is an increased potential for an unanticipated impact on the overall number of members assigned into the health plans.

Failure to accurately predict our medical expenses could negatively affect our financial position, results of operations or cash flows.

Our medical expense includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified.

While we utilize our predictive modeling technology and our executive dashboard, we still cannot be sure that our medical claims liability estimates are adequate or that adjustments to those estimates will not unfavorably impact our results of operations. For example, in the three months ended June 30, 2006 we adjusted medical expense by $9.7 million for adverse medical costs development from the first quarter of 2006.

Additionally, when we commence operations in a new state or region, we have limited information with which to estimate our medical claims liability. For example, we commenced operations in in Kentucky in November 2011, in Louisiana in February 2012, in Missouri and Washington in July 2012, expanded in Texas in March 2012, and expect to commence operations in New Hampshire and Kansas in 2013. For a period of time after the inception of business in these states, we base our estimates on state-provided historical actuarial data and limited actual incurred and received claims. The addition of new categories of individuals who are eligible for Medicaid under new legislation may pose the same difficulty in estimating our medical claims liability and utilization patterns.

From time to time in the past, our actual results have varied from our estimates, particularly in times of significant changes in the number of our members. The accuracy of our medical claims liability estimate may also affect our ability to take timely corrective actions, further harming our results.

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Assumptions and estimates are utilized in establishing premium deficiency reserves. In October 2012, we notified the Kentucky Cabinet for Health and Family Services that we were exercising a contractual right that we believes allows Kentucky Spirit to terminate its Medicaid managed care contract with the Commonwealth of Kentucky effective July 5, 2013. As a result, we recorded a premium deficiency reserve included in Medical costs expense of $63.0 million for the Kentucky contract in the quarter ended September 30, 2012. The premium deficiency reserve encompasses the contract period from October 1, 2012 through July 5, 2013. If our assumptions are inaccurate, our reserves may be inadequate to pay medical costs and there could be a material adverse effect on the results of operations and financial condition. In addition, if the contract is not terminated effective July 5, 2013, we may be required to increase our premium deficiency reserve and there could be a material adverse effect on the results of operations and financial condition.

Receipt of inadequate or significantly delayed premiums would negatively affect our revenues, profitability or cash flows.

Our premium revenues consist of fixed monthly payments per member and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide healthcare services as established by the state governments. We use a large portion of our revenues to pay the costs of healthcare services delivered to our members. If premiums do not increase when expenses related to medical services rise, our earnings will be affected negatively. In addition, our actual medical services costs may exceed our estimates, which would cause our health benefits ratio, or our expenses related to medical services as a percentage of premium revenue, to increase and our profits to decline. In addition, it is possible for a state to increase the rates payable to certain providers without granting a corresponding increase in premiums to us. If this were to occur in one or more of the states in which we operate, our profitability would be harmed. In addition, if there is a significant delay in our receipt of premiums to offset previously incurred health benefits costs, our cash flows or earnings could be negatively impacted.

In some instances, our base premiums are subject to an adjustment, or risk score, based on the acuity of our membership. Generally, the risk score is determined by the State analyzing encounter submissions of processed claims data to determine the acuity of our membership relative to the entire state's Medicaid membership. The risk score is dependent on several factors including our providers' completeness and quality of claims submission, our processing of the claim, submission of the processed claims in the form of encounters to the states' encounter systems and the states' acceptance and analysis of the encounter data. If the risk scores assigned to our premiums that are risk adjusted are not adequate or do not appropriately reflect the acuity of our membership, our earnings will be affected negatively.

Failure to effectively manage our medical costs or related administrative costs or uncontrollable epidemic or pandemic costs would reduce our profitability.

Our profitability depends, to a significant degree, on our ability to predict and effectively manage expenses related to health benefits. We have less control over the costs related to medical services than we do over our general and administrative expenses. Because of the narrow margins of our health plan business, relatively small changes in our health benefits ratio can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of use of healthcare services, hospital costs, pharmaceutical costs, major epidemics or pandemics, new medical technologies and other external factors, including general economic conditions such as inflation levels, are beyond our control and could reduce our ability to predict and effectively control the costs of providing health benefits. In 2009, the H1N1 influenza pandemic resulted in heightened costs due to increased physician visits and increased utilization of hospital emergency rooms and pharmaceutical costs. We cannot predict what impact an epidemic or pandemic will have on our costs in the future. Additionally, we may not be able to manage costs effectively in the future. If our costs related to health benefits increase, our profits could be reduced or we may not

remain profitable.

Our investment portfolio may suffer losses from changes in market interest rates and changes in market conditions which could materially and adversely affect our results of operations or liquidity.

As of September 30, 2012, we had $936.5 million in cash, cash equivalents and short-term investments and $593.2 million of long-term investments and restricted deposits. We maintain an investment portfolio of cash equivalents and short-term and long-term investments in a variety of securities which may include asset backed securities, bank deposits, commercial paper, certificates of deposit, money market funds, municipal bonds, corporate bonds, instruments of the U.S. Treasury and other government corporations and agencies, insurance contracts and equity securities. These investments are subject to general credit, liquidity, market and interest rate risks. Substantially all of these securities are subject to interest rate and credit risk and will decline in value if interest rates increase or one of the issuers' credit ratings is reduced. As a result, we may experience a reduction in value or loss of liquidity of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition.

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Our investments in state, municipal and corporate securities are not guaranteed by the United States government which could materially and adversely affect our results of operation, liquidity or financial condition.

As of September 30, 2012, we had $551.9 million of investments in state, municipal and corporate securities. These securities are not guaranteed by the United States government. State and municipal securities are subject to additional credit risk based upon each local municipality's tax revenues and financial stability. As a result, we may experience a reduction in value or loss of liquidity of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition.

Difficulties in executing our acquisition strategy could adversely affect our business.

Historically, the acquisition of Medicaid and specialty services businesses, contract rights and related assets of other health plans both in our existing service areas and in new markets has accounted for a significant amount of our growth. Many of the other potential purchasers have greater financial resources than we have. In addition, many of the sellers are interested either in (a) selling, along with their Medicaid assets, other assets in which we do not have an interest or (b) selling their companies, including their liabilities, as opposed to the assets of their ongoing businesses.

We generally are required to obtain regulatory approval from one or more state agencies when making acquisitions. In the case of an acquisition of a business located in a state in which we do not currently operate, we would be required to obtain the necessary licenses to operate in that state. In addition, even if we already operate in a state in which we acquire a new business, we would be required to obtain additional regulatory approval if the acquisition would result in our operating in an area of the state in which we did not operate previously, and we could be required to renegotiate provider contracts of the acquired business. We cannot provide any assurance that we would be able to comply with these regulatory requirements for an acquisition in a timely manner, or at all. In deciding whether to approve a proposed acquisition, state regulators may consider a number of factors outside our control, including giving preference to competing offers made by locally owned entities or by not-for-profit entities.

We also may be unable to obtain sufficient additional capital resources for future acquisitions. If we are unable to effectively execute our acquisition strategy, our future growth will suffer and our results of operations could be harmed.

Execution of our growth strategy may increase costs or liabilities, or create disruptions in our business.

We pursue acquisitions of other companies or businesses from time to time. Although we review the records of companies or businesses we plan to acquire, even an in-depth review of records may not reveal existing or potential problems or permit us to become familiar enough with a business to assess fully its capabilities and deficiencies. As a result, we may assume unanticipated liabilities or adverse operating conditions, or an acquisition may not perform as well as expected. We face the risk that the returns on acquisitions will not support the expenditures or indebtedness incurred to acquire such businesses, or the capital expenditures needed to develop such businesses. We also face the risk that we will not be able to integrate acquisitions into our existing operations effectively without substantial expense, delay or other operational or financial problems. Integration may be hindered by, among other things, differing procedures, including internal controls, business practices and technology systems. We may need to divert more management resources to integration than we planned, which may adversely affect our ability to pursue other profitable activities.

In addition to the difficulties we may face in identifying and consummating acquisitions, we will also be required to integrate and consolidate any acquired business or assets with our existing operations. This may include the integration of:

• additional personnel who are not familiar with our operations and corporate culture;
• provider networks that may operate on different terms than our existing networks;
• existing members, who may decide to switch to another healthcare plan; or
• disparate administrative, accounting and finance, and information systems.

Additionally, our growth strategy includes start-up operations in new markets or new products in existing markets. We may incur significant expenses prior to commencement of operations and the receipt of revenue. As a result, these start-up operations may decrease our profitability. We also face the risk that we will not be able to integrate start-up operations into our existing operations effectively without substantial expense, delay or other operational or financial problems. In the event we pursue any opportunity to diversify our business internationally, we would become subject to additional risks, including, but not limited to, political risk, an unfamiliar regulatory regime, currency exchange risk and exchange controls, cultural and language differences, foreign tax issues, and different labor laws and practices.

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Accordingly, we may be unable to identify, consummate and integrate future acquisitions or start-up operations successfully or operate acquired or new businesses profitably.

Acquisitions of unfamiliar new businesses could negatively impact our business.

We are subject to the expenditures and risks associated with entering into any new line of business. Our failure to properly manage these expenditures and risks could have a negative impact on our overall business. For example, effective July 2008, we completed the previously announced acquisition of Celtic Group, Inc., the parent company of Celtic Insurance Company, or Celtic. Celtic is a national individual health insurance provider that provides health insurance to individual customers and their families. While we believed that the addition of Celtic would be complementary to our business, we had not previously operated in the individual health care industry.

If competing managed care programs are unwilling to purchase specialty services from us, we may not be able to successfully implement our strategy of diversifying our business lines.

We are seeking to diversify our business lines into areas that complement our Medicaid business in order to grow our revenue stream and balance our dependence on Medicaid risk reimbursement. In order to diversify our business, we must succeed in selling the services of our specialty subsidiaries not only to our managed care plans, but to programs operated by third-parties. Some of these third-party programs may compete with us in some markets, and they therefore may be unwilling to purchase specialty services from us. In any event, the offering of these services will require marketing activities that differ significantly from the manner in which we seek to increase revenues from our Medicaid programs. Our inability to market specialty services to other programs may impair our ability to execute our business strategy.

Failure to achieve timely profitability in any business would negatively affect our results of operations.

Business expansion costs associated with a new business can be substantial. For example, in order to obtain a certificate of authority in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to obtain a state contract and process claims. If we were unsuccessful in obtaining the necessary license, winning the bid to provide service or attracting members in numbers sufficient to cover our costs, any new business of ours would fail. We also could be obligated by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or recover business expansion costs. The expenses associated with starting up a new business could have a significant impact on our results of operations if we are unable to achieve profitable operations in a timely fashion.

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

The securities and credit markets have been experiencing extreme volatility and disruption over the past several years. The availability of credit, from virtually all types of lenders, has been restricted. Such conditions may persist during 2012 and beyond. In the event we need access to additional capital to pay our operating expenses, make payments on our indebtedness, pay capital expenditures, or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant, particularly if we are unable to access our existing credit facility.

Our access to additional financing will depend on a variety of factors such as prevailing economic and credit market conditions, the general availability of credit, the overall availability of credit to our industry, our credit ratings and credit capacity, and perceptions of our financial prospects. Similarly, our access to funds may be impaired if

regulatory authorities or rating agencies take negative actions against us. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms or at all. We believe that if credit could be obtained, the terms and costs of such credit could be significantly less favorable to us than what was obtained in our most recent financings.

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We derive a majority of our premium revenues from operations in a small number of states, and our financial position, results of operations or cash flows would be materially affected by a decrease in premium revenues or profitability in any one of those states.

Operations in a few states have accounted for most of our premium revenues to date. If we were unable to continue to operate in any of our current states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on legislative or other governmental or regulatory actions and decisions, economic conditions and similar factors in those states. For example, states we currently serve may bid out their Medicaid program through a Request for Proposal, or RFP, process. Our inability to continue to operate in any of the states in which we operate would harm our business.

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

We compete for members principally on the basis of size and quality of provider network, benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state Medicaid programs that reimburse providers as care is provided. In addition, the impact of health care reform and potential growth in our segment may attract new competitors. Subject to limited exceptions by federally approved state applications, the federal government requires that there be choices for Medicaid recipients among managed care programs. Voluntary programs, increases in the number of competitors and mandated competition may limit our ability to increase our market share.

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

In addition, in order to increase our membership in the markets we currently serve, we believe that we must continue to develop and implement community-specific products, alliances with key providers and localized outreach and educational programs. If we are unable to develop and implement these initiatives, or if our competitors are more successful than we are in doing so, we may not be able to further penetrate our existing markets.

If we are unable to maintain relationships with our provider networks, our profitability may be harmed.

Our profitability depends, in large part, upon our ability to contract favorably with hospitals, physicians and other healthcare providers. Our provider arrangements with our primary care physicians, specialists and hospitals generally may be cancelled by either party without cause upon 90 to 120 days prior written notice. We cannot provide any assurance that we will be able to continue to renew our existing contracts or enter into new contracts enabling us to service our members profitably.

From time to time providers assert or threaten to assert claims seeking to terminate non-cancelable agreements due to alleged actions or inactions by us. Even if these allegations represent attempts to avoid or renegotiate contractual terms that have become economically disadvantageous to the providers, it is possible that in the future a provider may pursue such a claim successfully. In addition, we are aware that other managed care organizations have been subject to class action suits by physicians with respect to claim payment procedures, and we may be subject to similar claims. Regardless of whether any claims brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management’s attention. As a result, we may incur significant

expenses and may be unable to operate our business effectively.

We will be required to establish acceptable provider networks prior to entering new markets. We may be unable to enter into agreements with providers in new markets on a timely basis or under favorable terms. If we are unable to retain our current provider contracts or enter into new provider contracts timely or on favorable terms, our profitability will be harmed.

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We may be unable to attract and retain key personnel.

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our business. If we lose one or more members of our senior management team, including our chief executive officer, Michael F. Neidorff, who has been instrumental in developing our business strategy and forging our business relationships, our business and financial position, results of operations or cash flows could be harmed. Our ability to replace any departed members of our senior management or other key employees may be difficult and may take an extended period of time because of the limited number of individuals in the Medicaid managed care and specialty services industry with the breadth of skills and experience required to operate and successfully expand a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel.

Negative publicity regarding the managed care industry may harm our business and financial position, results of operations or cash flows.

The managed care industry has received negative publicity. This publicity has led to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. These factors may adversely affect our ability to market our services, require us to change our services, and increase the regulatory burdens under which we operate. Any of these factors may increase the costs of doing business and adversely affect our financial position, results of operations or cash flows.

Claims relating to medical malpractice could cause us to incur significant expenses.

Our providers and employees involved in medical care decisions may be subject to medical malpractice claims. In addition, some states have adopted legislation that permits managed care organizations to be held liable for negligent treatment decisions, credentialing or benefits coverage determinations. Claims of this nature, if successful, could result in substantial damage awards against us and our providers that could exceed the limits of any applicable insurance coverage. Therefore, successful malpractice or tort claims asserted against us, our providers or our employees could adversely affect our financial condition and profitability. Even if any claims brought against us are unsuccessful or without merit, they would still be time consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively.

Loss of providers due to increased insurance costs could adversely affect our business.

Our providers routinely purchase insurance to help protect themselves against medical malpractice claims. In recent years, the costs of maintaining commercially reasonable levels of such insurance have increased dramatically, and these costs are expected to increase to even greater levels in the future. As a result of the level of these costs, providers may decide to leave the practice of medicine or to limit their practice to certain areas, which may not address the needs of Medicaid participants. We rely on retaining a sufficient number of providers in order to maintain a certain level of service. If a significant number of our providers exit our provider networks or the practice of medicine generally, we may be unable to replace them in a timely manner, if at all, and our business could be adversely affected.

Growth in the number of Medicaid-eligible persons could cause our financial position, results of operations or cash flows to suffer if state and federal budgets decrease or do not increase.

Less favorable economic conditions may cause our membership to increase as more people become eligible to receive Medicaid benefits. During such economic downturns, however, state and federal budgets could decrease, causing states to attempt to cut healthcare programs, benefits and rates. Additionally, the number of individuals eligible for

Medicaid managed care will likely increase as a result of the health care reform legislation. We cannot predict the impact of changes in the United States economic environment or other economic or political events, including acts of terrorism or related military action, on federal or state funding of healthcare programs or on the size of the population eligible for the programs we operate. If federal or state funding decreases or remains unchanged while our membership increases, our results of operations will suffer.

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Growth in the number of Medicaid-eligible persons may be countercyclical, which could cause our financial position, results of operations or cash flows to suffer when general economic conditions are improving.

Historically, the number of persons eligible to receive Medicaid benefits has increased more rapidly during periods of rising unemployment, corresponding to less favorable general economic conditions. Conversely, this number may grow more slowly or even decline if economic conditions improve. Therefore, improvements in general economic conditions may cause our membership levels to decrease, thereby causing our financial position, results of operations or cash flows to suffer, which could lead to decreases in our stock price during periods in which stock prices in general are increasing.

If we are unable to integrate and manage our information systems effectively, our operations could be disrupted.

Our operations depend significantly on effective information systems. The information gathered and processed by our information systems assists us in, among other things, monitoring utilization and other cost factors, processing provider claims, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status and other information.

Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs and regulatory requirements. Moreover, our acquisition activity requires frequent transitions to or from, and the integration of, various information systems. We regularly upgrade and expand our information systems' capabilities. If we experience difficulties with the transition to or from information systems or are unable to properly maintain or expand our information systems, we could suffer, among other things, from operational disruptions, loss of existing members and difficulty in attracting new members, regulatory problems and increases in administrative expenses. In addition, our ability to integrate and manage our information systems may be impaired as the result of events outside our control, including acts of nature, such as earthquakes or fires, or acts of terrorists.

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

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

We may not be able to obtain or maintain adequate insurance.

We maintain liability insurance, subject to limits and deductibles, for claims that could result from providing or failing to provide managed care and related services. These claims could be substantial. We believe that our present insurance coverage and reserves are adequate to cover currently estimated exposures. We cannot provide any assurance that we will be able to obtain adequate insurance coverage in the future at acceptable costs or that we will not incur significant liabilities in excess of policy limits.

From time to time, we may become involved in costly and time-consuming litigation and other regulatory proceedings, which require significant attention from our management.

We are a defendant from time to time in lawsuits and regulatory actions relating to our business. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such

proceedings. An unfavorable outcome could have a material adverse impact on our business and financial position, results of operations or cash flows. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and time consuming and require significant attention from our management. For example, we have been named in a recently-filed securities lawsuit seeking class action and we have in the past, or may be subject to in the future, IRS examinations, securities class action lawsuits or similar regulatory actions. Any such matters could harm our business and financial position, results of operations or cash flows.

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An impairment charge with respect to our recorded goodwill and intangible assets could have a material impact on our results of operations.

Goodwill and other intangible assets were $309.4 million as of December 31, 2011 and $277.7 million as of September 30, 2012. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. Changes in business strategy, government regulations or economic or market conditions have resulted and may result in impairments of our goodwill and other intangible assets at any time in the future. Our judgments regarding the existence of impairment indicators are based on, among other things, legal factors, market conditions, and operational performance. For example, the non-renewal of our health plan contracts with the state in which they operate may be an indicator of impairment.

If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill and other intangible assets, such revision could result in a non-cash impairment charge that could have a material impact on our results of operations in the period in which the impairment occurs.

An unauthorized disclosure of sensitive or confidential member information could have an adverse effect on our business.

As part of our normal operations, we collect, process and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act. The American Recovery and Reinvestment Act of 2009 further expands the coverage of HIPAA by, among other things, extending the privacy and security provisions, requiring new disclosures if a data breach occurs, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions and increasing penalties for violations. Despite the security measures we have in place to ensure compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, whether by us or a third party, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

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ITEM 2. Unregistered Sales of Equity Securities and Use of Proceeds.

Issuer Purchases of Equity Securities
Third Quarter 2012

Period	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs[2]
July 1 – July 31, 2012	3,427	$36.67	—	1,667,724
August 1 – August 31, 2012	2,252	40.21	—	1,667,724
September 1 – September 30, 2012	3,941	37.27	—	1,667,724
Total	9,620	$37.74	—	1,667,724

(1) Shares acquired represent shares relinquished to the Company by certain employees for payment of taxes or option cost upon vesting of restricted stock units or option exercise.
(2) Our Board of Directors adopted a stock repurchase program of up to 4,000,000 shares. No duration has been placed on the repurchase program.

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ITEM 6. Exhibits.

Exhibits.

EXHIBIT NUMBER	DESCRIPTION
10.1[1]	Amendment C (Version 2.3) to the contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.
10.2*	Amendment No. 3 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff
10.3*	Amendment No. 1 to Executive Severance and Change in Control Agreement
12.1	Computation of ratio of earnings to fixed charges.
31.1	Certification of Chairman, President and Chief Executive Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Executive Vice President and Chief Financial Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chairman, President and Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Executive Vice President and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.1	XBRL Taxonomy Instance Document.
101.2	XBRL Taxonomy Extension Schema Document.
101.3	XBRL Taxonomy Extension Calculation Linkbase Document.
101.4	XBRL Taxonomy Extension Definition Linkbase Document.
101.5	XBRL Taxonomy Extension Label Linkbase Document.
101.6	XBRL Taxonomy Extension Presentation Linkbase Document.

[1] The Company has requested confidential treatment of the redacted portions of this exhibit pursuant to Rule 24b-2 under the Securities Exchange Act of 1934, as amended, and has separately filed a complete copy of this exhibit with the Securities and Exchange Commission.

* Indicates a management contract or compensatory plan or arrangement.

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized as of October 23, 2012.

CENTENE CORPORATION

By: /s/ MICHAEL F. NEIDORFF
Chairman, President and Chief Executive Officer
(principal executive officer)

By: /s/ WILLIAM N. SCHEFFEL
Executive Vice President and Chief Financial Officer
(principal financial officer)

By: /s/ JEFFREY A. SCHWANEKE
Senior Vice President, Corporate Controller and Chief Accounting Officer
(principal accounting officer)