CENTENE CORP
Form 10-Q
April 24, 2012

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

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# FORM 10-Q

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(Mark One)

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

For the quarterly period ended March 31, 2012

OR

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

For the transition period from to

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Commission file number: 001-31826

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

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

As of April 12, 2012, the registrant had 51,464,001 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 expressio 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;
- inflation;
- provider 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.

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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)

| | March 31, 2012 | December 31, 2011 |
|---|---|---|
| ASSETS | | |
| Current assets: | | |
| Cash and cash equivalents | $432,998 | $573,698 |
| Premium and related receivables | 278,233 | 157,450 |
| Short-term investments | 126,221 | 130,499 |
| Other current assets | 82,925 | 78,363 |
| Total current assets | 920,377 | 940,010 |
| Long-term investments | 605,866 | 506,140 |
| Restricted deposits | 37,361 | 26,818 |
| Property, software and equipment, net | 352,710 | 349,622 |
| Goodwill | 281,981 | 281,981 |
| Intangible assets, net | 26,122 | 27,430 |
| Other long-term assets | 58,730 | 58,335 |
| Total assets | $2,283,147 | $2,190,336 |
| | | |
| LIABILITIES AND STOCKHOLDERS’ EQUITY | | |
| Current liabilities: | | |
| Medical claims liability | $708,754 | $607,985 |
| Accounts payable and accrued expenses | 158,356 | 216,504 |
| Unearned revenue | 17,977 | 9,890 |
| Current portion of long-term debt | 3,235 | 3,234 |
| Total current liabilities | 888,322 | 837,613 |
| Long-term debt | 347,162 | 348,344 |
| Other long-term liabilities | 68,544 | 67,960 |
| Total liabilities | 1,304,028 | 1,253,917 |
| | | |
| Commitments and contingencies | | |
| | | |
| Stockholders’ equity: | | |
| Common stock, $.001 par value; authorized 100,000,000 shares; 54,214,037 issued and 51,458,501 outstanding at March 31, 2012, and 53,586,726 issued and 50,864,618 outstanding at December 31, 2011 | 54 | 54 |
| Additional paid-in capital | 443,111 | 421,981 |
| Accumulated other comprehensive income: | | |
| Unrealized gain on investments, net of tax | 6,237 | 5,761 |

| | | |
|---|---|---|
| Retained earnings | 588,939 | 564,961 |
| Treasury stock, at cost (2,755,536 and 2,722,108 shares, respectively) | (58,632) | (57,123) |
| Total Centene stockholders' equity | 979,709 | 935,634 |
| Noncontrolling interest | (590) | 785 |
| Total stockholders' equity | 979,119 | 936,419 |
| Total liabilities and stockholders' equity | $2,283,147 | $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 March 31, 2012 | 2011 |
|---|---|---|
| Revenues: | | |
| Premium | $ 1,634,850 | $ 1,152,777 |
| Service | 28,618 | 26,384 |
| Premium and service revenues | 1,663,468 | 1,179,161 |
| Premium tax | 48,680 | 37,196 |
| Total revenues | 1,712,148 | 1,216,357 |
| Expenses: | | |
| Medical costs | 1,442,676 | 978,567 |
| Cost of services | 23,337 | 20,176 |
| General and administrative expenses | 163,187 | 141,088 |
| Premium tax expense | 48,750 | 37,429 |
| Total operating expenses | 1,677,950 | 1,177,260 |
| Earnings from operations | 34,198 | 39,097 |
| Other income (expense): | | |
| Investment and other income | 5,291 | 3,749 |
| Interest expense | (4,799) | (5,695) |
| Earnings from operations, before income tax expense | 34,690 | 37,151 |
| Income tax expense | 12,087 | 14,328 |
| Net earnings | 22,603 | 22,823 |
| Noncontrolling interest | (1,375) | (922) |
| Net earnings attributable to Centene Corporation | $ 23,978 | $ 23,745 |
| | | |
| Net earnings per common share attributable to Centene Corporation: | | |
| Basic earnings per common share | $ 0.47 | $ 0.48 |
| Diluted earnings per common share | $ 0.45 | $ 0.46 |
| | | |
| Weighted average number of common shares outstanding: | | |
| Basic | 51,125,674 | 49,750,430 |
| Diluted | 53,509,243 | 51,811,721 |

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 March 31, | |
|---|---|---|
| | 2012 | 2011 |
| Net earnings | $22,603 | $22,823 |
| Reclassification adjustment, net of tax | 28 | 169 |
| Change in unrealized gains on investments, net of tax | 448 | (624) |
| Other comprehensive earnings | 476 | (455) |
| Comprehensive earnings | 23,079 | 22,368 |
| Comprehensive earnings attributable to the noncontrolling interest | (1,375) | (922) |
| Comprehensive earnings attributable to Centene Corporation | $24,454 | $23,290 |

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)

Three Months Ended March 31, 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 | — | — | — | — | 23,978 | — | — | (1,375) | 22,603 |
| Change in unrealized investment gain, net of $309 tax | — | — | — | 476 | — | — | — | — | 476 |
| Total comprehensive earnings | | | | | | | | | 23,079 |
| Common stock issued for employee benefit plans | 627,311 | — | 9,283 | — | — | — | — | — | 9,283 |
| Common stock repurchases | — | — | — | — | — | 33,428 | (1,509) | — | (1,509) |
| Stock compensation expense | — | — | 6,375 | — | — | — | — | — | 6,375 |
| Excess tax benefits from stock compensation | — | — | 5,472 | — | — | — | — | — | 5,472 |
| Balance, March 31, 2012 | 54,214,037 | $ 54 | $ 443,111 | $ 6,237 | $ 588,939 | 2,755,536 | $ (58,632) | $ (590) | $ 979,119 |

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)

| | Three Months Ended March 31, | |
|---|---|---|
| | 2012 | 2011 |
| Cash flows from operating activities: | | |
| Net earnings | $22,603 | $22,823 |
| Adjustments to reconcile net earnings to net cash provided by operating activities | | |
| Depreciation and amortization | 16,613 | 14,325 |
| Stock compensation expense | 6,375 | 4,394 |
| Deferred income taxes | 5,855 | (700) |
| Changes in assets and liabilities | | |
| Premium and related receivables | (120,784) | 4,216 |
| Other current assets | (10,723) | (1,636) |
| Other assets | 524 | 151 |
| Medical claims liabilities | 100,769 | 13,430 |
| Unearned revenue | 8,576 | 10,106 |
| Accounts payable and accrued expenses | (60,826) | 26,268 |
| Other operating activities | (1,078) | 614 |
| Net cash (used in) provided by operating activities | (32,096) | 93,991 |
| Cash flows from investing activities: | | |
| Capital expenditures | (14,980) | (16,882) |
| Purchases of investments | (255,212) | (40,423) |
| Sales and maturities of investments | 149,341 | 45,327 |
| Net cash used in investing activities | (120,851) | (11,978) |
| Cash flows from financing activities: | | |
| Proceeds from exercise of stock options | 9,079 | 6,518 |
| Proceeds from borrowings | — | 127,300 |
| Payment of long-term debt | (795) | (152,577) |
| Excess tax benefits from stock compensation | 5,472 | 1,132 |
| Common stock repurchases | (1,509) | (402) |
| Debt issue costs | — | (6,105) |
| Net cash provided by (used in) financing activities | 12,247 | (24,134) |
| Net (decrease) increase in cash and cash equivalents | (140,700) | 57,879 |
| Cash and cash equivalents, beginning of period | 573,698 | 434,166 |
| Cash and cash equivalents, end of period | $432,998 | $492,045 |
| | | |
| Supplemental disclosures of cash flow information: | | |
| Interest paid | $1,589 | $1,714 |
| Income taxes paid | $20,514 | $9,567 |
| | | |
| Supplemental disclosure of non-cash investing and financing activities: | | |
| Capital expenditures | $381 | $1,477 |

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 March 31, 2011, the net impact of the reclassification increased Medical Costs and decreased General & Administrative Expense by $21,493.

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:

| | March 31, 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 | $39,678 | $ 602 | $ (22) | $40,258 | $ 29,014 | $ 638 | $ (13) | $29,639 |
| Corporate securities | 260,568 | 4,476 | (403) | 264,641 | 186,018 | 3,762 | (751) | 189,029 |
| Restricted certificates of deposit | 9,475 | — | — | 9,475 | 5,890 | — | — | 5,890 |
| Restricted cash equivalents | 13,692 | — | — | 13,692 | 13,775 | — | — | 13,775 |
| Municipal securities: | | | | | | | | |
| General obligation | 125,974 | 2,376 | — | 128,350 | 126,806 | 2,828 | (26) | 129,608 |
| Pre-refunded | 28,164 | 336 | — | 28,500 | 33,247 | 465 | — | 33,712 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Revenue | 109,343 | 2,272 | (4) | 111,611 | 118,507 | 2,387 | (34) | 120,860 |
| Variable rate demand notes | 75,035 | — | — | 75,035 | 64,658 | — | — | 64,658 |
| Asset backed securities | 71,026 | 767 | (25) | 71,768 | 51,779 | 430 | (17) | 52,192 |
| Cost and equity method investments | 11,343 | — | — | 11,343 | 9,395 | — | — | 9,395 |
| Life insurance contracts | 14,775 | — | — | 14,775 | 14,699 | — | — | 14,699 |
| Total | $759,073 | $ 10,829 | $ (454) | $769,448 | $ 653,788 | $ 10,510 | $ (841) | $663,457 |

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 March 31, 2012, 39% of the Company's investments in securities recorded at fair value that carry a rating by Moody's or S&P were rated AAA, 72% were rated AA- or higher, and 99% were rated A- or higher. At March 31, 2012, the Company held certificates of deposit, life insurance contracts and cost and equity method invesments 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:

| | March 31, 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 | $(22) | $11,055 | $— | $— | $(13) | $2,184 | $— | $— |
| Corporate securities | (403) | 54,385 | — | — | (751) | 23,040 | — | — |
| Municipal securities: | | | | | | | | |
| General obligation | — | — | — | — | (26) | 3,710 | — | — |
| Revenue | (4) | 2,929 | — | — | (34) | 12,597 | — | — |
| Asset backed securities | (25) | 13,802 | — | — | (17) | 20,417 | — | — |
| Total | $(454) | $82,171 | $— | $— | $(841) | $61,948 | $— | $— |

As of March 31, 2012, the gross unrealized losses were generated from 42 positions out of a total of 402 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.

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

| | March 31, 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 | $125,065 | $126,221 | $30,389 | $30,389 | $129,232 | $130,499 | $19,666 | $19,666 |
| One year through five years | 497,808 | 506,530 | 6,921 | 6,972 | 406,140 | 413,953 | 7,085 | 7,152 |
| Five years through ten years | 31,969 | 31,989 | — | — | 34,945 | 34,961 | — | — |
| Greater than ten years | 66,921 | 67,347 | — | — | 56,720 | 57,226 | — | — |
| Total | $721,763 | $732,087 | $37,310 | $37,361 | $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.

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 March 31, | |
|---|---|---|
| | 2012 | 2011 |
| Gains | $ 8 | $ 133 |
| Losses | (10 ) | (15 ) |
| Net realized gains | $ (2 ) | $ 118 |

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 $2,908 and $2,512 was recorded in the three months ended March 31, 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. |

The following table summarizes fair value measurements by level at March 31, 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 | $ 432,998 | $ | $ | $ 432,998 |
| | | | | |
| Investments available for sale: | | | | |
| U.S. Treasury securities and obligations of U.S. government corporations and agencies | $ 22,885 | $ 3,179 | $ | $ 26,064 |
| Corporate securities | | 264,641 | | 264,641 |
| Municipal securities: | | | | |
| General obligation | | 128,350 | | 128,350 |
| Pre-refunded | | 28,500 | | 28,500 |
| Revenue | | 111,611 | | 111,611 |
| Variable rate demand notes | | 75,035 | | 75,035 |
| Asset backed securities | | 71,768 | | 71,768 |
| Total investments | $ 22,885 | $ 683,084 | $ | $ 705,969 |
| | | | | |
| Restricted deposits available for sale: | | | | |
| Cash and cash equivalents | $ 13,692 | $ | $ | $ 13,692 |
| Certificates of deposit | 9,475 | | | 9,475 |
| U.S. Treasury securities and obligations of U.S. government corporations and agencies | 14,194 | | | 14,194 |
| Total restricted deposits | $ 37,361 | $ | $ | $ 37,361 |
| | | | | |
| Other long-term assets: | | | | |
| Interest rate swap contract | $ | $ 10,918 | $ | $ 10,918 |
| | | | | |
| Total assets at fair value | $ 493,244 | $ 694,002 | $ | $ 1,187,246 |

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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 |

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 March 31, 2012, there were $1,218 transfers from Level I to Level II and $3,113 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 $26,118 and $24,094 as of March 31, 2012 and December 31, 2011, respectively.

4. Debt

Debt consists of the following:

| | March 31, 2012 | December 31, 2011 |
|---|---|---|
| Senior notes, at par | $ 250,000 | $ 250,000 |
| | (2,685 ) | (2,814 ) |

| | | |
|---|---|---|
| Unamortized discount on Senior notes | | |
| Interest rate swap fair value | 10,918 | 11,431 |
| Senior notes, net | 258,233 | 258,617 |
| Revolving credit agreement | | |
| Mortgage notes payable | 86,242 | 86,948 |
| Capital leases and other | 5,922 | 6,013 |
| Total debt | 350,397 | 351,578 |
| Less current portion | (3,235 ) | (3,234 ) |
| Long-term debt | $ 347,162 | $ 348,344 |

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 March 31, 2012, the unamortized debt discount was $2,685. 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 March 31, 2012, the fair value of the interest rate swap increased the fair value of the notes by $10,918. At March 31, 2012, the variable rate of the swap was 3.99%.

Revolving Credit Agreement

The Company has $350,000 revolving credit facility, or the revolver, 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 March 31, 2012, the Company had no borrowings outstanding under the agreement, leaving availability of $350,000.

The Company has outstanding letters of credit of $36,131 as of March 31, 2012, which are not part of the revolver. The letters of credit bore interest at 1.66%.

5. Earnings Per Share

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

| | Three Months Ended March 31, | |
|---|---|---|
| | 2012 | 2011 |
| Earnings attributable to Centene Corporation common shareholders: | | |
| Earnings from continuing operations, net of tax | $ 23,978 | $ 23,745 |
| Shares used in computing per share amounts: | | |
| | 51,125,674 | 49,750,430 |

| | | | | |
|---|---|---|---|---|
| Weighted average number of common shares outstanding | | | | |
| Common stock equivalents (as determined by applying the treasury stock method) | | 2,383,569 | | 2,061,291 |
| Weighted average number of common shares and potential dilutive common shares outstanding | | 53,509,243 | | 51,811,721 |
| | | | | |
| Net earnings per share attributable to Centene Corporation: | | | | |
| Basic earnings per common share | $ | 0.47 | $ | 0.48 |
| Diluted earnings per common share | $ | 0.45 | $ | 0.46 |

The calculation of diluted earnings per common share for the three months ended March 31, 2012 and 2011 excludes the impact of 4,291 and 124,946 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

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6. 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, long-term care programs, 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 included in the Specialty Services segment.

Segment information for the three months ended March 31, 2012, follows:

| | Medicaid Managed Care | Specialty Services | Eliminations | Consolidated Total |
|---|---|---|---|---|
| Premium and service revenues from external customers | $ 1,455,735 | $ 207,733 | $ — | $ 1,663,468 |
| Premium and service revenues from internal customers | 14,852 | 324,079 | (338,931 ) | — |
| Total premium and service revenues | $ 1,470,587 | $ 531,812 | $ (338,931 ) | $ 1,663,468 |
| | | | | |
| Earnings from operations | $ 13,974 | $ 20,224 | $ — | $ 34,198 |

Segment information for the three months ended March 31, 2011, follows:

| | Medicaid Managed Care | Specialty Services | Eliminations | Consolidated Total |
|---|---|---|---|---|
| Premium and service revenues from external customers | $ 1,000,639 | $ 178,522 | $ — | $ 1,179,161 |
| Premium and service revenues from internal customers | 15,747 | 147,120 | (162,867 ) | — |
| Total premium and service revenues | $ 1,016,386 | $ 325,642 | $ (162,867 ) | $ 1,179,161 |
| | | | | |
| Earnings from operations | $ 28,066 | $ 11,031 | $ — | $ 39,097 |

7. Subsequent Events

In April 2012, Centene was notified by the Ohio Department of Job and Family Services that Buckeye Community Health Plan, Centene's Ohio subsidiary, was not awarded a contract to continue serving Medicaid members in Ohio, effective January 2013. The Company has filed a formal protest contesting the awards.

As a result of this event, Centene will conduct a test for recoverability of the assets of Buckeye Community Health Plan including goodwill and intangible assets. Absent a successful appeal, the Company expects a material non-cash impairment charge will be recorded in its 2012 consolidated statement of operations for the year ended December 31, 2012. As of March 31, 2012, Buckeye Community Health Plan had goodwill and net intangible assets of $42,827.

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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

Our financial performance for the first quarter of 2012 is summarized as follows:

— Quarter-end at-risk managed care membership of 2,149,500 an increase of 607,000 members year over year.
— Premium and service revenues of $1.7 billion, representing 41.1% growth year over year.
— Health Benefits Ratio of 88.2%, compared to 84.9% in 2011.
— General and Administrative expense ratio of 9.8%, compared to 12.0% in 2011.
— Diluted net earnings per share of $0.45, compared to $0.46 in the prior year.
— Total operating cash flows of $(32.1) million.

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 three-year contract with the Kentucky Finance and Administration Cabinet to serve Medicaid beneficiaries.

— Louisiana. In February 2012, our joint venture subsidiary, Louisiana Healthcare Connections, began operating under a new contract in Louisiana to provide healthcare services to Medicaid enrollees participating in the Bayou Health program. In addition, Nurtur, our subsidiary which provides life, health and wellness programs, commenced operations to provide disease management services for state employees in Louisiana beginning in January 2012.

— Mississippi. In January 2011, we began operating through the Mississippi Coordinated Access Network program to serve Medicaid beneficiaries. During the second quarter of 2011, the contract effectiveness provision was amended and accordingly, revenue, medical cost and related earnings for January 1, 2011 through March 31, 2011 were recorded during the second quarter of 2011. As a result, the recognition of earnings of approximately $0.07 per diluted share related to the Mississippi operations from the first quarter were recorded in the second quarter of 2011. General and administrative expenses related to the Mississippi operations were recognized in our consolidated statement of operations during the first quarter of 2011.

— Ohio. In October 2011, Buckeye Community Health Plan 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.

— Texas. In February 2011, we began operating under an additional STAR+PLUS ABD contract in the Dallas service area and in September 2011, added additional membership through the contiguous county expansion. 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.

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

— We expect to realize the full year benefit of business commenced during 2011 in Arizona, Illinois, Kentucky, Ohio and Texas, as discussed above.

— In January 2012, we announced that we were selected to contract with the Washington Health Care Authority to serve Medicaid beneficiaries in the state. Operations are expected to commence in the third quarter of 2012.

— In February 2012, we announced that we were selected to contract with the Office of Administration for Missouri to serve Medicaid beneficiaries in the Central, Eastern and Western Managed Care Regions of the state. Operations are expected to commence in the third quarter of 2012.

— During 2012, Louisiana Healthcare Connections, our joint venture subsidiary, will continue its three-phase membership roll-out to provide services in all three of the state's geographical service areas, which is expected to be completed during the second quarter of 2012.

In April 2012, we were notified by the Ohio Department of Job and Family Services that Buckeye Community Health Plan, our Ohio subsidiary, was not awarded a contract to continue serving Medicaid members in Ohio, effective January 2013. We have filed a formal protest contesting the awards. As a result of this event, we will conduct a test for recoverability of the assets of Buckeye Community Health Plan including goodwill and intangible assets during the second quarter of 2012. Absent a successful appeal, we expect a material, non-cash impairment charge will be recorded in the 2012 consolidated statement of operations for the year ended December 31, 2012. As of March 31, 2012, Buckeye Community Health Plan had goodwill and net intangible assets of $42.8 million.

MEMBERSHIP

From March 31, 2011 to March 31, 2012, we increased our at-risk managed care membership by 607,000, or 39.4%. The following table sets forth our membership by state for our managed care organizations:

| | March 31, | | December 31, |
|---|---|---|---|
| | 2012 | 2011 | 2011 |
| Arizona | 23,100 | 22,600 | 23,700 |
| Florida | 199,500 | 188,800 | 198,300 |
| Georgia | 306,000 | 303,300 | 298,200 |
| Illinois | 17,400 | | 16,300 |
| Indiana | 206,300 | 209,400 | 206,900 |
| Kentucky | 145,700 | | 180,700 |
| Louisiana | 51,300 | | |
| Massachusetts | 36,000 | 34,100 | 35,700 |
| Mississippi | 29,500 | | 31,600 |
| Ohio | 161,000 | 160,900 | 159,900 |
| South Carolina | 86,700 | 84,900 | 82,900 |
| Texas | 811,000 | 456,700 | 503,800 |
| Wisconsin | 76,000 | 81,800 | 78,000 |
| | 2,149,500 | 1,542,500 | 1,816,000 |

| | | | |
|---|---|---|---|
| Total at-risk membership | | | |
| Non-risk membership | | 10,400 | 4,900 |
| Total | 2,149,500 | 1,552,900 | 1,820,900 |

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

| | March 31, 2012 | March 31, 2011 | December 31, 2011 |
|---|---|---|---|
| Medicaid | 1,634,800 | 1,169,700 | 1,336,800 |
| CHIP & Foster Care | 218,800 | 208,900 | 213,900 |
| ABD & Medicare | 247,400 | 123,800 | 218,000 |
| Hybrid Programs | 41,500 | 35,200 | 40,500 |
| Long-term Care | 7,000 | 4,900 | 6,800 |
| Total at-risk membership | 2,149,500 | 1,542,500 | 1,816,000 |
| Non-risk membership | | 10,400 | 4,900 |
| Total | 2,149,500 | 1,552,900 | 1,820,900 |

The following table provides supplemental information of other membership categories:

| | March 31, 2012 | March 31, 2011 | December 31, 2011 |
|---|---|---|---|
| Cenpatico Behavioral Health: | | | |
| Arizona | 162,100 | 172,700 | 168,900 |
| Kansas | 46,000 | 44,000 | 46,200 |

RESULTS OF CONTINUING OPERATIONS

The following discussion and analysis is based on our consolidated statements of operations, which reflect our results of operations for the three months ended March 31, 2012 and 2011, prepared in accordance with generally accepted accounting principles in the United States.

Summarized comparative financial data for the three months ended March 31 is as follows ($ in millions):

| | 2012 | 2011 | % Change 2011-2012 |
|---|---|---|---|
| Premium | $ 1,634.9 | $ 1,152.8 | 41.8 % |
| Service | 28.6 | 26.4 | 8.5 % |
| Premium and service revenues | 1,663.5 | 1,179.2 | 41.1 % |
| Premium tax | 48.7 | 37.2 | 30.9 % |
| Total revenues | 1,712.2 | 1,216.4 | 40.8 % |
| Medical costs | 1,442.7 | 978.6 | 47.4 % |
| Cost of services | 23.3 | 20.2 | 15.7 % |
| General and administrative expenses | 163.2 | 141.1 | 15.7 % |

| | | | |
|---|---|---|---|
| Premium tax expense | 48.8 | 37.4 | 30.2 % |
| Earnings from operations | 34.2 | 39.1 | (12.5 )% |
| Investment and other income, net | 0.5 | (2.0 ) | (125.3 )% |
| Earnings from continuing operations, before income tax expense | 34.7 | 37.1 | (6.6 )% |
| Income tax expense | 12.1 | 14.3 | (15.6 )% |
| Net earnings | 22.6 | 22.8 | (1.0 )% |
| Noncontrolling interest | (1.4 ) | (0.9 ) | 49.1 % |
| Net earnings attributable to Centene Corporation | $ 24.0 | $ 23.7 | 1.0 % |
| | | | |
| Diluted earnings per common share attributable to Centene Corporation | $ 0.45 | $ 0.46 | (2.2 )% |

Three Months Ended March 31, 2012 Compared to Three Months Ended March 31, 2011

Premium and Service Revenues

Premium and service revenues increased 41.1% in the three months ended March 31, 2012 over the corresponding period in 2011 as a result of the addition of our Mississippi, Illinois, Kentucky and Louisiana contracts, Texas and Arizona expansion, pharmacy carve-ins, and membership growth. During the three months ended March 31, 2012, we received premium rate adjustments which yielded a net 0% composite change across all of our markets.

While the Mississippi plan began operating January 1, 2011, the contract effectiveness provision wasn't amended until the second quarter of 2011 and accordingly, revenue, medical costs and related earnings for January 1, 2011 through March 31, 2011 were recorded during the second quarter of 2011. As a result, the recognition of $52.8 million of premium and service revenue related to the first quarter of 2011 was recognized during the second quarter of 2011.

Operating Expenses

Medical Costs

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately predict 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 March 31:

| | 2012 | 2011 |
|---|---|---|
| Medicaid and CHIP | 87.4% | 84.0% |
| ABD and Medicare | 89.0 | 87.4 |
| Specialty Services | 90.7 | 85.4 |
| Total | 88.2 | 84.9 |

The consolidated HBR for the three months ended March 31, 2012, of 88.2% was an increase of 330 basis points over the comparable period in 2011. The increase is primarily due to (1) the addition of our Kentucky market which we continue to record at a high HBR, (2) higher medical costs in Texas specifically in March and a September 1, 2011 premium rate decrease in our existing Texas service areas (excluding the expansion), (3) higher medical costs in our

South Carolina market and (4) increased medical costs in our individual heath business.

General and Administrative Expenses

General and administrative expenses, or G&A, increased by $22.1 million in the three months ended March 31, 2012 compared to the corresponding period in 2011.  This was primarily due to expenses for additional staff and facilities to support our membership growth.

The consolidated G&A expense ratio for the three months ended March 31, 2012 and 2011 was 9.8%, and 12.0%, respectively.  The year over year decrease in the G&A expense ratio reflects the leveraging of our expenses over higher revenues in 2012 and a reduction in performance based compensation expense in 2012.  The G&A ratio in 2011 reflects a 50 basis point increase as a result of the general and administrative costs recorded in our Mississippi market for the first quarter without recording the corresponding revenue.



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Other Income (Expense)

The following table summarizes the components of other income (expense) for the three months ended March 31, ($ in millions):

| | 2012 | 2011 |
|---|---|---|
| Investment income | $ 5.3 | $ 3.7 |
| Interest expense | (4.8) | (5.7) |
| Other income (expense), net | $ 0.5 | $ (2.0) |

The increase in investment income in 2012 reflects an increase in investment balances over 2011. Interest expense decreased during the quarter by $0.9 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 year.

Income Tax Expense

Excluding the effects of noncontrolling interests, our effective tax rate for the three months ended March 31, 2012 was 33.5% compared to 37.6% in the corresponding period in 2011. The decrease in the effective tax rate reflects 1) lower state taxes as a result of certain discrete tax events, 2) an increase in disqualifying dispositions of incentive stock options which lowered the federal effective rate, partially offset by 3) higher state and federal taxes due to losses in new markets where no tax benefit can be recorded.

Segment Results

The following table summarizes our operating results by segment for the three months ended March 31, (in millions):

| | 2012 | 2011 | % Change 2011-2012 |
|---|---|---|---|
| Premium and Service Revenues | | | |
| Medicaid Managed Care | $ 1,470.6 | $ 1,016.4 | 44.7 % |
| Specialty Services | 531.8 | 325.7 | 63.3 % |
| Eliminations | (338.9 ) | (162.9 ) | 108.1 % |
| Consolidated Total | $ 1,663.5 | $ 1,179.2 | 41.1 % |
| | | | |
| Earnings from Operations | | | |
| Medicaid Managed Care | $ 14.0 | $ 28.1 | (50.2 )% |
| Specialty Services | 20.2 | 11.0 | 83.3 % |
| Consolidated Total | $ 34.2 | $ 39.1 | (12.5 )% |

Medicaid Managed Care

Premium and service revenues increased 44.7% in the three months ended March 31, 2012, due to the addition of our Mississippi, Illinois, Kentucky and Louisiana contracts, Texas expansion, pharmacy carve-ins, and membership growth. Earnings from operations decreased 50.2% in the three months ended March 31, 2012, primarily due to (1) the addition of our Kentucky market which we continue to record at a high HBR, (2) higher medical costs in Texas specifically in March and a September 1, 2011 premium rate decrease in our existing Texas service areas (excluding the expansion), (3) higher medical costs in South Carolina and (4) increased business expansion costs.

Specialty Services

Premium and service revenues increased 63.3% in the three months ended March 31, 2012, due to growth in our Medicaid segment and the associated specialty services provided to this increased membership as well as the Arizona expansion and carve-in of pharmacy services in Texas and Ohio. Earnings from operations increased 83.3% in the three months ended March 31, 2012, reflecting growth in our pharmacy business and the associated specialty services provided to our increased Medicaid membership, partially offset by the decrease in earnings in the individual health insurance business.

## LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows for the three months ended March 31, 2012 and 2011, used in the discussion of liquidity and capital resources ($ in millions).

| | Three Months Ended March 31, | |
|---|---|---|
| | 2012 | 2011 |
| Net cash (used in) provided by operating activities | $ (32.1) | $ 94.0 |
| Net cash used in investing activities | (120.8) | (12.0) |
| Net cash provided by (used in) financing activities | 12.2 | (24.1) |
| Net (decrease) increase in cash and cash equivalents | $ (140.7) | $ 57.9 |

Cash Flows (Used In) Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our revolving credit facility. Operating activities used cash of $32.1 million in the three months ended March 31, 2012, compared to providing cash of $94.0 million in the comparable period in 2011. The cash used in operations was primarily due to the delay of $71.2 million in premium payments from one of our state customers and the timing of payments from other state customers totaling $49.6 million, partially offset by an increase in medical claims liabilities related to the start up of our Louisiana plan as well as expansion of our Texas health plan.

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 by several days until the following month, 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. The table below details the impact to cash flows from operations from the timing of payments from our states ($ in millions).

| | Three Months Ended March 31, | | | |
|---|---|---|---|---|
| | 2012 | | 2011 | |
| Premium and related receivables | $ | (120.8) | $ | 4.2 |
| Unearned revenue | | 8.6 | | 10.1 |
| Net (decrease) increase in operating cash flow | $ | (112.2) | $ | 14.3 |

Cash Flows Used in Investing Activities

Investing activities used cash of $120.8 million in the three months ended March 31, 2012 and $12.0 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 March 31, 2012, our investment portfolio consisted primarily of fixed-income securities with an average duration of 2.1 years. We had unregulated cash and investments of $35.5 million at March 31, 2012, compared to $38.2 million at December 31, 2011.

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We spent $15.0 million and $16.9 million in the three months ended March 31, 2012 and 2011, respectively, on capital expenditures for system enhancements, a new datacenter and market expansions. We anticipate spending approximately $70 million additional on capital expenditures in 2012 primarily associated with system enhancements and market expansions.

Cash Flows Provided by (Used In) Financing Activities

Our financing activities provided cash of $12.2 million in the three months ended March 31, 2012 compared to using cash $24.1 million in the comparable period in 2011. During 2012, our financing activities primarily related to proceeds from stock option exercises. During 2011, our financing activities primarily related to repayments and proceeds of long-term debt.

At March 31, 2012, we had working capital, defined as current assets less current liabilities, of $32.1 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 March 31, 2012, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 26.4%, compared to 27.3% at December 31, 2011. Excluding the $77.2 million non-recourse mortgage note, our debt to capital ratio is 21.8%, 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 March 31, 2012, our subsidiaries had aggregate statutory capital and surplus of $652.8 million, compared with the required minimum aggregate statutory capital and surplus requirements of $374.7 million. 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 March 31, 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 March 31, 2012, we had short-term investments of $126.2 million and long-term investments of $643.3 million, including restricted deposits of $37.4 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 March 31, 2012, the fair value of our fixed income investments would decrease by approximately $13.7 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 March 31, 2012, the fair value of our debt would decrease by approximately $12.1 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

In 2011, the inflation rate for medical care costs was 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 March 31, 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 March 31, 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 March 31, 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 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. 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. For example, one Congressional budget proposal for 2013 includes federal cuts to Medicaid funding (i.e. through block grants and other means) by as much as $800 billion over the next 10 years.

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 the Medicaid eligible population increases, 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.

In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act were enacted. The Acts and the regulations promulgated thereunder require states to expand Medicaid to all individuals under age 65 with incomes up to 133% of the federal poverty level beginning January 1, 2014. Such regulations permit states to phase-in these eligibility requirements if such phase-in plan is approved by the Secretary of the U.S. Department of Health and Human Services. Additional federal funds will be provided to states in 2014, but the amount of the federal support decreases each year. Since the states have to pay for a portion of the care, states may reduce our rates in order to afford the additional beneficiaries.

The American Reinvestment and Recovery Act of 2009 and subsequent legislation provided additional federal Medicaid funding for states' Medicaid expenditures between October 1, 2008 and June 30, 2011. During this time period, the share of Medicaid costs that were paid for by the federal government went up, and each state's share went down. Now that this additional funding has expired, we cannot predict whether the states will have sufficient funds

for their Medicaid programs.

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 June 30, 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. In April 2012, we were notified by the Oho Department of Job and Family Services (ODJFS) that we were not awarded a contract in Ohio commencing January 2013 and have since filed a formal protest. 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.

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.

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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.

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
- loss of our right to participate in various markets
- increased difficulty in selling our products and services
- 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 most individually identifiable health information. The HITECH Act expanded the scope of these provisions by mandating individual notification in instances of data breach, 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.

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.

In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act were enacted. This legislation provides comprehensive changes to the U.S. health care system, which will be phased in at various stages through 2018. Among other things, by January 1, 2014, states will be required to expand their Medicaid programs to provide eligibility to nearly all people under age 65 with income below 133 percent of the federal poverty line. As a result, millions of low-income adults without children who currently cannot qualify for coverage, as well as many low-income parents and, in some instances, children now covered through CHIP, will be made eligible for Medicaid. States were permitted to begin such expansions on April 1, 2010.

The legislation also 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. Federal legislation has been introduced to permit states as early as 2014 (as opposed to 2017 as is in the current health care reform law) to opt out of the health care reform law and provide their own model in certain circumstances. 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.

In addition, there have been a number of lawsuits filed that challenge all or part of the health care reform law. A number of the lawsuits have been ruled on by federal appeals courts and those rulings were not consistent. Several parties including the current administration have appealed to the U.S. Supreme Court. The Supreme Court heard oral argument in these cases in late March, but has not yet issued a ruling. We cannot predict exactly when the court will rule. Various Congressional leaders have indicated a desire to revisit some or all of the health care reform law. While the U.S. House of Representatives voted to repeal the whole health care reform law, the U.S. Senate voted against such a repeal, and there have separately been a number of bills introduced that would repeal, change or defund certain provisions of the law. The 2011 budget eliminated two programs funded under the health care reform law – the Consumer Operated and Oriented Plan (CO-OP) and the Free Choice Voucher programs. Further, a number of states have passed legislation intended to block various requirements of the health care reform law. Because of these challenges, we cannot predict whether any or all of the legislation will be implemented as enacted, overturned, repealed or modified.

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.

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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.

In August 2011, the Budget Control Act of 2011 was enacted into law in order to increase the federal debt ceiling. The law included spending cuts of nearly $1 trillion over 10 years, but did not include any cuts to Medicaid. The law further created a Congressional committee that was tasked with recommending a plan that would reduce the federal deficit by another $1.5 trillion over 10 years. The committee was required to recommend a plan to Congress by the end of November 2011. The committee was not able to come to agreement and recommend a plan to Congress. Therefore, automatic spending cuts will become effective. While changes to Medicaid could have been considered by the committee, Medicaid is not subject to the automatic spending cuts.

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 Mississippi in January 2011, in Illinois in May 2011, in Kentucky in November 2011, in Louisiana in February 2012, expanded in Texas in March 2012, and expect to commence operations in Missouri and Washington in the third quarter of 2012. 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.

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.

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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 March 31, 2012, we had $559.1 million in cash, cash equivalents and short-term investments and $643.3 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. For example, in the third quarter of 2008, we recorded a loss on investments of approximately $4.5 million due to a loss in a money market fund.

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 March 31, 2012, we had $608.1 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
• 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.

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 Medicaid contract with Kansas, which terminated December 31, 2006, together with our Medicaid contract with Missouri, accounted for $317.0 million in revenue for the year ended December 31, 2006. In April 2012, we were notified by the ODJFS that we were not awarded a contract in Ohio commencing January 2013 and have since filed a formal protest. 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.

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 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.

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.

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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 in the past, or may be subject to in the future, securities class action lawsuits, IRS examinations or similar regulatory actions. Any such matters could harm our business and financial position, results of operations or cash flows.

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
First 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 Programs2 |
|---|---|---|---|---|
| January 1 – January 31, 2012 | 9,532 | $ 44.10 | — | 1,667,724 |
| February 1 – February 29, 2012 | 23,518 | 45.55 | — | 1,667,724 |
| March 1 – March 31, 2012 | 378 | 46.87 | — | 1,667,724 |
| Total | 33,428 | $ 45.15 | — | 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 |
|---|---|
| 10.11 | Amendment A (Version 2.1) to Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc. |
| 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. |
| 101.12 | XBRL Taxonomy Instance Document. |
| 101.22 | XBRL Taxonomy Extension Schema Document. |
| 101.32 | XBRL Taxonomy Extension Calculation Linkbase Document. |
| 101.42 | XBRL Taxonomy Extension Definition Linkbase Document. |
| 101.52 | XBRL Taxonomy Extension Label Linkbase Document. |
| 101.62 | 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.

2 XBRL (Extensible Business Reporting Language) information is furnished and not filed or a part of a registration statement or prospectus for purposes of sections 11 or 12 of the Securities Act of 1933, is deemed not filed for purposes of section 18 of the Securities Exchange Act of 1934, and otherwise is not subject to liability under these sections.

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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 April 24, 2012.

CENTENE CORPORATION

| | |
|---|---|
| By: | /s/ MICHAEL F. NEIDORFF<br>Chairman, President and Chief Executive Officer<br>(principal executive officer) |
| By: | /s/ WILLIAM N. SCHEFFEL<br>Executive Vice President and Chief Financial Officer<br>(principal financial officer) |
| By: | /s/ JEFFREY A. SCHWANEKE<br>Senior Vice President, Corporate Controller and Chief Accounting Officer<br>(principal accounting officer) |