CENTENE CORP
Form 10-Q
April 23, 2013

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

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

For the quarterly period ended March 31, 2013
OR

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

For the transition period from to

Commission file number: 001-31826

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

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

Registrant's telephone number, including area code:

(314) 725-4477

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

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

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

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

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

As of April 12, 2013, the registrant had 54,420,651 shares of common stock outstanding.

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

All statements, other than statements of current or historical fact, contained in this filing are forward-looking statements. We have attempted to identify these statements by terminology including “believe,” “anticipate,” “plan,” “expect,” “estimate,” “intend,” “seek,” “target,” “goal,” “may,” “will,” “should,” “can,” “continue” and other similar words or expressions in connection with, among other things, any discussion of future operating or financial performance. In particular, these statements include statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, including those entitled “Management's Discussion and Analysis of Financial Condition and Results of Operations,” Part I, Item 1A. “Risk Factors,” and Part I, Item 3 “Legal Proceedings.” Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, including economic, regulatory, competitive and other factors that may cause our or our industry’s actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

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

- our ability to accurately predict and effectively manage health benefits and other operating expenses;
- competition;
- membership and revenue projections;
- timing of regulatory contract approval;
- changes in healthcare practices;
- changes in federal or state laws or regulations, including the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act and any regulations enacted thereunder;
- changes in expected contract start dates;
- changes in expected closing dates for acquisitions;
- inflation;
- provider and state contract changes;
- new technologies;
- reduction in provider payments by governmental payors;
- major epidemics;
- disasters and numerous other factors affecting the delivery and cost of healthcare;
- the expiration, cancellation or suspension of our Medicare or Medicaid managed care contracts by federal or 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, 2013	December 31, 2012
ASSETS		
Current assets:		
Cash and cash equivalents	$730,791	$843,952
Premium and related receivables	320,371	263,452
Short-term investments	146,107	139,118
Other current assets	178,002	127,080
Total current assets	1,375,271	1,373,602
Long-term investments	748,307	614,723
Restricted deposits	39,344	34,793
Property, software and equipment, net	382,853	377,726
Goodwill	256,288	256,288
Intangible assets, net	19,287	20,268
Other long-term assets	65,807	64,282
Total assets	$2,887,157	$2,741,682
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$1,067,032	$926,302
Premium deficiency reserve	18,130	41,475
Accounts payable and accrued expenses	180,338	191,343
Unearned revenue	38,175	34,597
Current portion of long-term debt	3,419	3,373
Total current liabilities	1,307,094	1,197,090
Long-term debt	532,734	535,481
Other long-term liabilities	60,799	55,344
Total liabilities	1,900,627	1,787,915
Commitments and contingencies		
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; 55,432,271 issued and 52,410,000 outstanding at March 31, 2013, and 55,339,160 issued and 52,329,248 outstanding at December 31, 2012	55	55
Additional paid-in capital	461,360	450,856
Accumulated other comprehensive income:		
Unrealized gain on investments, net of tax	4,900	5,189
Retained earnings	589,822	566,820
Treasury stock, at cost (3,022,271 and 3,009,912 shares, respectively)	(70,429)	(69,864)
Total Centene stockholders' equity	985,708	953,056
Noncontrolling interest	822	711
Total stockholders' equity	986,530	953,767

Total liabilities and stockholders' equity	$2,887,157	$2,741,682

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,	
	2013	2012
Revenues:		
Premium	$2,509,049	$1,634,850
Service	33,194	28,618
Premium and service revenues	2,542,243	1,663,468
Premium tax	103,649	48,680
Total revenues	2,645,892	1,712,148
Expenses:		
Medical costs	2,267,400	1,442,676
Cost of services	25,065	23,337
General and administrative expenses	210,348	163,187
Premium tax expense	102,975	48,750
Total operating expenses	2,605,788	1,677,950
Earnings from operations	40,104	34,198
Other income (expense):		
Investment and other income	4,471	5,291
Interest expense	(6,625)	(4,799)
Earnings before income tax expense	37,950	34,690
Income tax expense	15,039	12,087
Net earnings	22,911	22,603
Noncontrolling interest	(91)	(1,375)
Net earnings attributable to Centene Corporation	$23,002	$23,978
Net earnings per common share attributable to Centene Corporation:		
Basic earnings per common share	$0.44	$0.47
Diluted earnings per common share	$0.42	$0.45
Weighted average number of common shares outstanding:		
Basic	52,357,119	51,125,674
Diluted	54,266,928	53,509,243

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,	
	2013	2012
Net earnings	$22,911	$22,603
Reclassification adjustment, net of tax	(29)	(28)
Change in unrealized gains on investments, net of tax	(260)	504
Other comprehensive earnings (loss)	(289)	476
Comprehensive earnings	22,622	23,079
Comprehensive earnings (loss) attributable to the noncontrolling interest	(91)	(1,375)
Comprehensive earnings attributable to Centene Corporation	$22,713	$24,454

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, 2013

	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, 2012	55,339,160	$55	$450,856	$5,189	$566,820	3,009,912	$(69,864)	$711	$953,767
Comprehensive Earnings:									
Net earnings	—	—	—	—	23,002	—	—	(91)	22,911
Change in unrealized investment gain, net of $(162) tax	—	—	—	(289)	—	—	—	—	(289)
Total comprehensive earnings									22,622
Common stock issued for employee benefit plans	93,111	—	1,613	—	—	—	—	—	1,613
Common stock repurchases	—	—	—	—	—	12,359	(565)	—	(565)
Stock compensation expense	—	—	8,375	—	—	—	—	—	8,375
Excess tax benefits from stock compensation	—	—	516	—	—	—	—	—	516
Contribution from noncontrolling interest	—	—	—	—	—	—	—	202	202
Balance, March 31, 2013	55,432,271	$55	$461,360	$4,900	$589,822	3,022,271	$(70,429)	$822	$986,530

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,	
	2013	2012
Cash flows from operating activities:		
Net earnings	$22,911	$22,603
Adjustments to reconcile net earnings to net cash provided by operating activities		
Depreciation and amortization	15,691	16,613
Stock compensation expense	8,375	6,375
Deferred income taxes	986	5,855
Changes in assets and liabilities		
Premium and related receivables	(56,734)	(120,784)
Other current assets	(50,537)	(10,723)
Other assets	5	524
Medical claims liabilities	117,385	100,769
Unearned revenue	3,578	8,576
Accounts payable and accrued expenses	(22,745)	(60,826)
Other operating activities	4,078	(1,078)
Net cash provided by (used in) operating activities	42,993	(32,096)
Cash flows from investing activities:		
Capital expenditures	(10,654)	(14,980)
Purchases of investments	(358,131)	(255,212)
Sales and maturities of investments	212,508	149,341
Net cash used in investing activities	(156,277)	(120,851)
Cash flows from financing activities:		
Proceeds from exercise of stock options	1,408	9,079
Payment of long-term debt	(776)	(795)
Excess tax benefits from stock compensation	515	5,472
Common stock repurchases	(565)	(1,509)
Contribution from noncontrolling interest	202	—
Debt issue costs	(661)	—
Net cash provided by financing activities	123	12,247
Net decrease in cash and cash equivalents	(113,161)	(140,700)
Cash and cash equivalents, beginning of period	843,952	573,698
Cash and cash equivalents, end of period	$730,791	$432,998
Supplemental disclosures of cash flow information:		
Interest paid	$1,410	$1,589
Income taxes paid	$2,205	$20,514

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, 2012. 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, 2012 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 2012 amounts in the notes to the consolidated financial statements have been reclassified to conform to the 2013 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

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, 2013				December 31, 2012			
	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	$235,510	$651	$(544)	$235,617	$117,434	$594	$(221)	$117,807
Corporate securities	337,051	5,224	(157)	342,118	315,807	5,101	(198)	320,710
Restricted certificates of deposit	5,891	—	—	5,891	5,890	—	—	5,890
Restricted cash equivalents	18,992	—	—	18,992	14,460	—	—	14,460
Municipal securities:								
General obligation	83,054	1,074	(31)	84,097	88,690	1,173	(26)	89,837
Pre-refunded	4,508	61	—	4,569	5,337	85	—	5,422
Revenue	86,108	1,133	(29)	87,212	84,726	1,331	(30)	86,027
Variable rate demand notes	44,050	—	—	44,050	37,685	—	—	37,685
Asset backed securities	83,123	1,081	(15)	84,189	83,295	1,197	(17)	84,475
Cost and equity method investments	11,918	—	—	11,918	11,298	—	—	11,298

Life insurance contracts	15,105	—	—	15,105	15,023	—	—	15,023
Total	$925,310	$9,224	$(776)	$933,758	$779,645	$9,481	$(492)	$788,634

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, 2013, 45% of the Company's investments in securities recorded at fair value that carry a rating by S&P or Moody's were rated AAA/Aaa, 65% were rated AA-/Aa3 or higher, and 95% were rated A-/A3 or higher. At March 31, 2013, the Company held certificates of deposit, life insurance contracts and cost and equity method investments which did not carry a credit rating.

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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, 2013				December 31, 2012			
	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	$(541)	$115,648	$(3)	$200	$(219)	$56,033	$(2)	$202
Corporate securities	(157)	37,484	—	—	(198)	44,758	—	—
Municipal securities:								
General obligation	(31)	3,575	—	—	(26)	8,464	—	—
Revenue	(8)	5,171	(21)	1,811	(30)	3,325	—	—
Asset backed securities	(15)	4,720	—	—	(17)	9,321	—	—
Total	$(752)	$166,598	$(24)	$2,011	$(490)	$121,901	$(2)	$202

As of March 31, 2013, the gross unrealized losses were generated from 35 positions out of a total of 368 positions. The decline in fair value of fixed income securities is a result of movement in interest rates subsequent to the purchase of the security.

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

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

	March 31, 2013				December 31, 2012			
	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	$145,078	$146,107	$32,270	$32,291	$138,011	$139,118	$34,403	$34,435
One year through five years	558,216	565,480	7,053	7,053	474,068	481,381	358	358
Five years through ten years	144,985	144,546	—	—	94,006	93,878	—	—
Greater than ten years	37,708	38,281	—	—	38,799	39,464	—	—
Total	$885,987	$894,414	$39,323	$39,344	$744,884	$753,841	$34,761	$34,793

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 cost and equity method investments 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.

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.

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Investment amortization of $2,543 and $2,908 was recorded in the three months ended March 31, 2013 and 2012, 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, 2013, for assets and liabilities measured at fair value on a recurring basis:

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$730,791	—	—	$730,791
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$202,163	$18,993	—	$221,156
Corporate securities	—	342,118	—	342,118
Municipal securities:				
General obligation	—	84,097	—	84,097
Pre-refunded	—	4,569	—	4,569
Revenue	—	87,212	—	87,212
Variable rate demand notes	—	44,050	—	44,050
Asset backed securities	—	84,189	—	84,189
Total investments	$202,163	$665,228	—	$867,391
Restricted deposits available for sale:				
Cash and cash equivalents	$18,992	—	—	$18,992
Certificates of deposit	5,891	—	—	5,891
U.S. Treasury securities and obligations of U.S. government corporations and agencies	14,461	—	—	14,461
Total restricted deposits	$39,344	—	—	$39,344
Other long-term assets: Interest rate swap contract	—	$14,821	—	$14,821
Total assets at fair value	$972,298	$680,049	—	$1,652,347

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The following table summarizes fair value measurements by level at December 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	$843,952	—	—	$843,952
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$57,114	$46,250	—	$103,364
Corporate securities	—	320,710	—	320,710
Municipal securities:				
General obligation	—	89,837	—	89,837
Pre-refunded	—	5,422	—	5,422
Revenue	—	86,027	—	86,027
Variable rate demand notes	—	37,685	—	37,685
Asset backed securities	—	84,475	—	84,475
Total investments	$57,114	$670,406	—	$727,520
Restricted deposits available for sale:				
Cash and cash equivalents	$14,460	—	—	$14,460
Certificates of deposit	5,890	—	—	5,890
U.S. Treasury securities and obligations of U.S. government corporations and agencies	14,443	—	—	14,443
Total restricted deposits	$34,793	—	—	$34,793
Other long-term assets: Interest rate swap contract	—	$16,304	—	$16,304
Total assets at fair value	$935,859	$686,710	—	$1,622,569

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, 2013, there were $2,783 of transfers from Level I to Level II and $26,089 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 $27,023 and $26,321 as of March 31, 2013 and December 31, 2012, respectively.

4. Debt

Debt consists of the following:

	March 31, 2013	December 31, 2012
Senior notes, at par	$425,000	$425,000
Unamortized premium on Senior notes	7,381	7,823
Interest rate swap fair value	14,821	16,304
Senior notes	447,202	449,127
Revolving credit agreement	—	—
Mortgage notes payable	83,345	84,081
Capital leases and other	5,606	5,646
Total debt	536,153	538,854
Less current portion	(3,419)	(3,373)
Long-term debt	$532,734	$535,481

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Senior Notes

In May 2011, the Company issued $250,000 non-callable 5.75% Senior Notes due June 1, 2017 (the $250,000 Notes) at a discount to yield 6%. In connection with the May 2011 issuance, the Company entered into an interest rate swap for a notional amount of $250,000. 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, 2013, the fair value of the interest rate swap increased the fair value of the notes by $14,821 and the variable interest rate of the swap was 3.79%.

In November 2012, the Company issued an additional $175,000 non-callable 5.75% Senior Notes due June 1, 2017 ($175,000 Add-on Notes) at a premium to yield 4.29%. The indenture governing the $250,000 Notes and the $175,000 Add-on Notes contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio. Interest is paid semi-annually in June and December. At March 31, 2013, the total net unamortized debt premium on the $250,000 Notes and $175,000 Add-on Notes was $7,381.

Revolving Credit Agreement

The Company has a $350,000 revolving credit facility due in January 2016. The revolver is unsecured and has non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio, a maximum debt to EBITDA ratio 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, 2013, the Company had no borrowings outstanding under the agreement.

In February 2013, the Company amended the $350,000 revolving credit facility to add an additional pricing tier and increased the maximum total debt to EBITDA ratio to 3.85 as of March 31, 2013, 3.50 as of June 30, 2013, 3.25 as of September 30, 2013 and 3.0 as of December 31, 2013 and thereafter.

The Company had outstanding letters of credit of $12,324 as of March 31, 2013, which were not part of the revolver. The letters of credit bore interest at 1.06% as of March 31, 2013.

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,	
	2013	2012
Net earnings attributable to Centene Corporation	$23,002	$23,978
Shares used in computing per share amounts:		
Weighted average number of common shares outstanding	52,357,119	51,125,674
Common stock equivalents (as determined by applying the treasury stock method)	1,909,809	2,383,569
Weighted average number of common shares and potential dilutive common shares outstanding	54,266,928	53,509,243
Net earnings per share attributable to Centene Corporation:		
Basic earnings per common share	$0.44	$0.47
Diluted earnings per common share	$0.42	$0.45

The calculation of diluted earnings per common share for the three months ended March 31, 2013 and 2012 excludes the impact of 23,351 and 4,291 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, correctional systems healthcare, health insurance exchanges, individual health insurance, life and health management, managed vision, pharmacy benefits management and telehealth services. The health plan in Massachusetts, operated by our individual health insurance business, is included in the Specialty Services segment.

In January 2013, the Company reclassified the health plan in Arizona, operated by our long-term care company, to the Medicaid Managed Care segment. As a result, the financial results of the Arizona health plan have been reclassified from the Specialty Services segment to the Medicaid Managed Care segment for all periods presented.

Segment information for the three months ended March 31, 2013, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$2,416,859	$125,384	$—	$2,542,243
Premium and service revenues from internal customers	10,463	562,895	(573,358)	—
Total premium and service revenues	$2,427,322	$688,279	$(573,358)	$2,542,243
Earnings from operations	$7,498	$32,606	$—	$40,104

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	$1,521,231	$142,237	$—	$1,663,468
Premium and service revenues from internal customers	14,852	324,079	(338,931)	—
Total premium and service revenues	$1,536,083	$466,316	$(338,931)	$1,663,468
Earnings from operations	$13,492	$20,706	$—	$34,198

7. Contingencies

In October 2012, the Company notified the Kentucky Cabinet for Health and Family Services (Cabinet) that it was exercising a contractual right that it believes allows the Company to terminate its Medicaid managed care contract with the Commonwealth of Kentucky (Commonwealth) effective July 5, 2013. The Company also filed a formal dispute with the Cabinet for damages incurred under the contract, which was later appealed to and denied by the Finance and Administration Cabinet on March 14, 2013. In response, the Company filed a lawsuit on April 12, 2013, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches.

The Company had previously filed a lawsuit in Franklin Circuit Court against the Commonwealth seeking declaratory relief. On April 5, 2013, the Commonwealth answered that lawsuit and filed counterclaims against the Company seeking declaratory relief and damages. The Franklin Circuit Court has issued a scheduling order setting the primary declaratory judgment claims for a hearing in May 2013. Those claims center on the Company's right to terminate the contract and the measure of liquidated damages, if any, associated with the termination.

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

8. Subsequent Events

In April 2013, the Company acquired AcariaHealth, a specialty pharmacy company, for approximately $146,200. The transaction consideration was financed through a combination of approximately 2.1 million shares of Centene common stock and approximately $55,400 of cash on hand.

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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

Key financial metrics for the first quarter of 2013 are summarized as follows:

- Quarter-end at-risk managed care membership of 2,686,100, an increase of 536,600 members, or 25% year over year.
- Premium and service revenues of $2.5 billion, representing 53% growth year over year.
- Health Benefits Ratio of 90.4%, compared to 88.2% in 2012.
- General and Administrative expense ratio of 8.3%, compared to 9.8% in 2012.
- Operating cash flow of $43.0 million for the first quarter of 2013.

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

- Kansas. In January 2013, our subsidiary, Sunflower State Health Plan, began operating under a statewide contract to serve members in the state's KanCare program, which includes TANF, ABD (dual and non-dual), foster care, LTC and CHIP beneficiaries.

- Louisiana. In February 2012, Louisiana Healthcare Connections (LHC), began operating under a new contract in Louisiana to provide healthcare services to Medicaid enrollees participating in the Bayou Health program. LHC completed its three-phase membership roll-out for the three geographical service areas during the second quarter of 2012. In November 2012, the covered services provided by LHC expanded to include pharmacy benefits.

- Mississippi. In December 2012, our subsidiary, Magnolia Health Plan, began operating under an expanded contract to provide managed care services statewide to certain Medicaid members as well as providing behavioral health services.

- Missouri. In July 2012, Home State Health Plan began operating under a new contract with the Office of Administration for Missouri to serve Medicaid beneficiaries in the Eastern, Central, and Western Managed Care Regions of the state.

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

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

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

- We expect to realize the full year benefit in 2013 of business commenced during 2012 in Louisiana, Mississippi, Missouri, Texas and Washington as discussed above.

- In April 2013, we completed the acquisition of AcariaHealth, a specialty pharmacy company, for approximately $146.2 million. The transaction consideration was financed through a combination of approximately 2.1 million

shares of Centene common stock and approximately $55.4 million of cash on hand.

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- In March 2013, our California subsidiary, California Health and Wellness Plan, was notified by the California Department of Health Care Services of its intent to award a contract, contingent upon successful completion of contract negotiations, to serve Medicaid beneficiaries in 18 rural counties. Under the contract, California Health and Wellness Plan will serve members under the state's Medi-Cal Managed Care Rural Expansion program. Upon execution of a contract and regulatory approval, enrollment is expected to begin in the second half of 2013.

- In March 2013, our joint venture subsidiary, Centurion, was notified by the Department of Corrections in Massachusetts that it had been awarded a contract to provide comprehensive healthcare services to individuals incarcerated in Massachusetts state correctional facilities. Centurion is a joint venture between Centene and MHM Services Inc., a national leader in providing healthcare services to correctional systems. Operations are expected to begin the third quarter of 2013.

- In January 2013, our Florida subsidiary, Sunshine State Health Plan, was notified by the Florida Agency for Health Care Administration that it has been recommended for a contract award in 10 of 11 regions of the Medicaid Managed Care Long Term Care program. Upon execution of a contract and regulatory approval, enrollment will be implemented by region, beginning in August 2013 and continuing through March 2014.

- In November 2012, our Illinois subsidiary, IlliniCare Health Plan, was selected to serve dual-eligible members in Cook, DuPage, Lake, Kane, Kankakee and Will counties (Greater Chicago region) as part of the Illinois Medicare-Medicaid Alignment Initiative. Enrollment is expected to begin in late 2013.

- In August 2012, we were notified by the Ohio Department of Job and Family Services (ODJFS) that Buckeye Community Health Plan (Buckeye), our Ohio subsidiary, was selected to serve Medicaid members in a dual-eligible demonstration program in three of Ohio's pre-determined seven regions: Northeast (Cleveland), Northwest (Toledo) and West Central (Dayton). This three-year program, which is part of the state of Ohio's Integrated Care Delivery System (ICDS) expansion, will serve those who have both Medicare and Medicaid eligibility. Enrollment is expected to begin in the second half of 2013.

- In June 2012, we were notified by the ODJFS that Buckeye was selected to be awarded a new and expanded contract to serve Medicaid members in Ohio. Under the new state contract, Buckeye will operate statewide through Ohio's three newly aligned regions (West, Central/Southeast, and Northeast). The expansion is expected to begin in July 2013.

- In May 2012, we announced that the Governor and Executive Council of New Hampshire had given approval for the Department of Health and Human Services to contract with our subsidiary, Granite State Health Plan, to serve Medicaid beneficiaries in New Hampshire. Operations are currently expected to commence in the second half of 2013.

In October 2012, the Company notified the Kentucky Cabinet for Health and Family Services (Cabinet) that it was exercising a contractual right that it believes allows the Company to terminate its Medicaid managed care contract with the Commonwealth of Kentucky (Commonwealth) effective July 5, 2013. The Company also filed a formal dispute with the Cabinet for damages incurred under the contract, which was later appealed to and denied by the Finance and Administration Cabinet on March 14, 2013. In response, the Company filed a lawsuit on April 12, 2013, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches.

The Company had previously filed a lawsuit in Franklin Circuit Court against the Commonwealth seeking declaratory relief. On April 5, 2013, the Commonwealth answered that lawsuit and filed counterclaims against the Company seeking declaratory relief and damages. The Franklin Circuit Court has issued a scheduling order setting the primary

declaratory judgment claims for a hearing in May 2013. Those claims center on the Company's right to terminate the contract and the measure of liquidated damages, if any, associated with the termination.

In March 2013, we were notified by the Arizona Health Care Cost Containment System that our Arizona subsidiary, Bridgeway Health Solutions of Arizona, LLC (Bridgeway), was not awarded a contract to serve acute care members in Arizona for the five years beginning October 1, 2013. The current contract termination is effective September 30, 2013. Bridgeway currently serves 16,200 Medicaid acute care members in Yavapai County.

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MEMBERSHIP

From March 31, 2012 to March 31, 2013, we increased our at-risk managed care membership by 536,600, or 25.0%. The following table sets forth our membership by state for our managed care organizations:

	March 31, 2013	December 31, 2012	March 31, 2012
Arizona	23,300	23,500	23,100
Florida	214,600	214,000	199,500
Georgia	314,000	313,700	306,000
Illinois	18,000	18,000	17,400
Indiana	202,400	204,000	206,300
Kansas	133,700	—	—
Kentucky	132,700	135,800	145,700
Louisiana	162,900	165,600	51,300
Massachusetts	17,300	21,500	36,000
Mississippi	77,000	77,200	29,500
Missouri	57,900	59,600	—
Ohio	157,700	157,800	161,000
South Carolina	90,100	90,100	86,700
Texas	948,400	949,900	811,000
Washington	63,500	57,200	—
Wisconsin	72,600	72,400	76,000
Total	2,686,100	2,560,300	2,149,500

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

	March 31, 2013	December 31, 2012	March 31, 2012
Medicaid	2,049,200	1,977,200	1,634,800
CHIP & Foster Care	267,900	237,700	218,800
ABD & Medicare	320,700	307,800	247,400
Hybrid Programs	24,600	29,100	41,500
Long-term Care	23,700	8,500	7,000
Total	2,686,100	2,560,300	2,149,500

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

	March 31, 2013	December 31, 2012	March 31, 2012
ABD	80,300	72,800	60,600
Long-term Care	16,100	7,700	6,400
Medicare	5,300	5,100	3,100
Total	101,700	85,600	70,100

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RESULTS OF OPERATIONS

The following discussion and analysis is based on our consolidated statements of operations, which reflect our results of operations for the three months ended March 31, 2013 and 2012, prepared in accordance with generally accepted accounting principles in the United States.

Summarized comparative financial data for the three months ended March 31, 2013 and 2012 is as follows ($ in millions):

	Three Months Ended March 31,			
	2013	2012	% Change 2012-2013	
Premium	$2,509.0	$1,634.9	53.5	%
Service	33.2	28.6	16.0	%
Premium and service revenues	2,542.2	1,663.5	52.8	%
Premium tax	103.7	48.7	112.9	%
Total revenues	2,645.9	1,712.2	54.5	%
Medical costs	2,267.4	1,442.7	57.2	%
Cost of services	25.1	23.3	7.4	%
General and administrative expenses	210.3	163.2	28.9	%
Premium tax expense	103.0	48.8	111.2	%
Earnings from operations	40.1	34.2	17.3	%
Investment and other income, net	(2.2)	0.5	(537.8)	%
Earnings before income tax expense	37.9	34.7	9.4	%
Income tax expense	15.0	12.1	24.4	%
Net earnings	22.9	22.6	1.4	%
Noncontrolling interest	(0.1)	(1.4)	(93.4)	%
Net earnings attributable to Centene Corporation	$23.0	$24.0	(4.1)	%
Diluted earnings per common share attributable to Centene Corporation	$0.42	$0.45	(6.7)	%

Three Months Ended March 31, 2013 Compared to Three Months Ended March 31, 2012

Revenues and Revenue Recognition

Premium and service revenues increased 52.8% in the three months ended March 31, 2013 over the corresponding period in 2012 primarily as a result of the Texas, Mississippi, and Louisiana expansions, pharmacy carve-in in Texas and Louisiana, and the additions of the Kansas, Missouri and Washington contracts. During the three months ended March 31, 2013, we received premium rate adjustments which yielded a net 0% composite change across all of our markets.

Operating Expenses

Medical Costs

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately estimate costs incurred. The Health Benefits Ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding premium taxes) and reflects the direct relationship between the premium received and the medical services provided. The table below depicts the HBR for our membership by member category for the three months ended March 31,:

	2013		2012	
Medicaid and CHIP	92.4	%	87.5	%
ABD and Medicare	88.0		89.3	

Specialty Services	82.9	89.7
Total	90.4	88.2

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The consolidated HBR for the three months ended March 31, 2013 was 90.4% compared to 88.2% in the same period in 2012. The increase compared to last year primarily reflects a higher level of flu costs during the first quarter of 2013 as well as a higher level of medical costs in new business.

General & Administrative Expenses

General and administrative expenses, or G&A, increased by $47.2 million in the three months ended March 31, 2013, compared to the corresponding period in 2012. This was primarily due to expenses for additional staff and facilities to support our membership growth as well as performance based compensation.

The consolidated G&A expense ratio for the three months ended March 31, 2013, and 2012 was 8.3%, and 9.8%, respectively. The year over year decrease reflects the leveraging of expenses over higher revenue.

Other Income (Expense)

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

	2013	2012
Investment income	$4.5	$5.3
Interest expense	(6.6)	(4.8)
Other income (expense), net	$(2.1)	$0.5

The decrease in investment income in 2013 reflects a decrease in investment returns over 2012. Interest expense increased in 2013 compared to 2012, reflecting the addition of $175 million of Senior Notes in the fourth quarter of 2012.

Income Tax Expense

Excluding the effects of noncontrolling interest, our effective tax rate for the three months ended March 31, 2013 was 39.5% compared to 33.5% in the corresponding period in 2012. The increase in the effective tax rate in 2013 reflects lower state taxes in 2012 as a result of certain discrete tax events and a decrease in disqualifying dispositions of incentive stock options which increased the federal effective rate in 2013.

Segment Results

In January 2013, the Company reclassified the health plan in Arizona, operated by our long-term care company, to the Medicaid Managed Care segment. As a result, the financial results of the Arizona health plan have been reclassified from the Specialty Services segment to the Medicaid Managed Care segment for all periods presented. The following table summarizes our operating results by segment for the three months ended March 31, (in millions):

	2013	2012	% Change 2012-2013
Premium and Service Revenues			
Medicaid Managed Care	$2,427.3	$1,536.1	58.0 %
Specialty Services	688.3	466.3	47.6 %
Eliminations	(573.4)	(338.9)	69.2 %
Consolidated Total	$2,542.2	$1,663.5	52.8 %
Earnings from Operations			
Medicaid Managed Care	$7.5	$13.5	(44.4)%

Specialty Services	32.6	20.7	57.5	%
Consolidated Total	$40.1	$34.2	17.3	%

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Medicaid Managed Care

Premium and service revenues increased 58.0% in the three months ended March 31, 2013, primarily as a result of the Texas, Mississippi, and Louisiana expansions, pharmacy carve-in in Texas and Louisiana, and the additions of the Kansas, Missouri and Washington contracts. Earnings from operations decreased $6.0 million between years primarily due to a higher level of flu costs during the first quarter of 2013 as well as a higher level of medical costs in new business.

Specialty Services

Premium and service revenues increased 47.6% in the three months ended March 31, 2013, due to the carve-in of pharmacy services in Texas and Louisiana, as well as the associated specialty services provided to the increased membership in the Medicaid segment. Earnings from operations increased $11.9 million in the three months ended March 31, 2013, reflecting improvement in our individual health insurance business as well as growth in our pharmacy business and the associated specialty services provided to our increased Medicaid membership.

LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows for the three months ended March 31, 2013 and 2012, used in the discussion of liquidity and capital resources ($ in millions).

	Three Months Ended March 31,	
	2013	2012
Net cash provided (used in) by operating activities	$43.0	$(32.1)
Net cash used in investing activities	(156.3)	(120.8)
Net cash provided by financing activities	0.1	12.2
Net decrease in cash and cash equivalents	$(113.2)	$(140.7)

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our revolving credit facility. Operating activities provided cash of $43.0 million in the three months ended March 31, 2013, compared to using $32.1 million in the comparable period in 2012. The cash provided by operations in 2013 was primarily related to an increase in medical claims liabilities including our new business in Kansas.

Cash flows from operations in each year were impacted by the timing of payments we receive from our states. States may prepay the following month premium payment, which we record as unearned revenue, or they may delay our premium payment, which we record as a receivable. We typically receive capitation payments monthly, however the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period. 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,	
	2013	2012
Premium and related receivables	$(56.7)	$(120.8)
Unearned revenue	3.6	8.6
Net decrease in operating cash flow	$(53.1)	$(112.2)

Cash Flows Used in Investing Activities

Investing activities used cash of $156.3 million in the three months ended March 31, 2013 and $120.8 million in the comparable period in 2012. Cash flows from investing activities in 2013 and 2012 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. We spent $10.7 million and $15.0 million in the three months ended March 31, 2013 and 2012, respectively, on capital expenditures for system enhancements and market expansions.

As of March 31, 2013, our investment portfolio consisted primarily of fixed-income securities with an average duration of 2.9 years. We had unregulated cash and investments of $45.5 million at March 31, 2013, compared to $37.3 million at December 31, 2012.

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Cash Flows Provided by Financing Activities

Our financing activities provided cash of $0.1 million in the three months ended March 31, 2013 compared to $12.2 million in the comparable period in 2012. During 2013, our financing activities primarily related to cash proceeds from the exercise of stock options.

Liquidity Metrics

In February 2013, we amended our $350.0 million revolving credit facility to add an additional pricing tier and increased the maximum total debt to EBITDA ratio to 3.85 as of March 31, 2013, 3.50 as of June 30, 2013, 3.25 as of September 30, 2013 and 3.0 as of December 31, 2013 and thereafter. As of March 31, 2013, we had no borrowings outstanding under our revolving credit facility, and we were in compliance with all covenants. As of March 31, 2013, the borrowing availability under our revolving credit facility was limited by the total debt to EBITDA ratio.

We had outstanding letters of credit of $12.3 million as of March 31, 2013, which were not part of our revolving credit facility. The letters of credit bore interest at 1.06% as of March 31, 2013.

At March 31, 2013, we had working capital, defined as current assets less current liabilities, of $68.2 million, as compared to $176.5 million at December 31, 2012. 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, 2013, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 35.2%, compared to 36.1% at December 31, 2012. Excluding the $74.7 million non-recourse mortgage note, our debt to capital ratio is 31.9%, compared to 32.7% at December 31, 2012. We utilize the debt to capital ratio as a measure, among others, of our leverage and financial flexibility.

2013 Expectations

In April 2013, we completed the acquisition of AcariaHealth, a specialty pharmacy company for approximately $146.2 million. The transaction consideration was financed through a combination of approximately 2.1 million shares of Centene common stock and approximately $55.4 million of cash on hand.

In April 2013, we filed an equity shelf registration statement on Form S-3 with the Securities and Exchange Commission, or the SEC, covering the issuance of equity securities including common stock. In addition, we filed a prospectus supplement covering the issuance of up to $15.3 million in common stock related to funding the escrow account for the acquisition of AcariaHealth.

We expect to make additional capital contributions to our insurance subsidiaries of approximately $270 million during the remainder of 2013 associated with our growth and approximately $60 million in additional capital expenditures in 2013 primarily associated with system enhancements and market expansions. These capital contributions and capital expenditures are expected to be funded by unregulated cash flow generation and borrowings on our revolving credit facility.

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, along with the issuance of shares of Centene common stock in connection with the acquisition of AcariaHealth discussed above will be sufficient to finance our general operations, acquisition of AcariaHealth 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.

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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, 2013, our subsidiaries had aggregate statutory capital and surplus of $1,115.9 million, compared with the required minimum aggregate statutory capital and surplus requirements of $661.2 million. Excluding our Kentucky health plan, we estimate our Risk Based Capital, or RBC, percentage to be in excess of 350% of the Authorized Control Level.

The National Association of Insurance Commissioners has adopted rules which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of March 31, 2013, 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, 2013, we had short-term investments of $146.1 million and long-term investments of $787.6 million, including restricted deposits of $39.3 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, 2013, the fair value of our fixed income investments would decrease by approximately $23.6 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, 2013, the fair value of our debt would decrease by approximately $10.6 million. An increase in interest rates decreases the fair value of the debt and conversely, a decrease in interest rates increases the value.

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

INFLATION

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

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

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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, 2013. 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, 2013.

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, 2013 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

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PART II
OTHER INFORMATION

ITEM 1. Legal Proceedings.

In October 2012, the Company notified the Kentucky Cabinet for Health and Family Services (Cabinet) that it was exercising a contractual right that it believes allows the Company to terminate its Medicaid managed care contract with the Commonwealth of Kentucky (Commonwealth) effective July 5, 2013. The Company also filed a formal dispute with the Cabinet for damages incurred under the contract, which was later appealed to and denied by the Finance and Administration Cabinet on March 14, 2013. In response, the Company filed a lawsuit on April 12, 2013, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches.
The Company had previously filed a lawsuit in Franklin Circuit Court against the Commonwealth seeking declaratory relief. On April 5, 2013, the Commonwealth answered that lawsuit and filed counterclaims against the Company seeking declaratory relief and damages. The Franklin Circuit Court has issued a scheduling order setting the primary declaratory judgment claims for a hearing in May 2013. Those claims center on the Company's right to terminate the contract and the measure of liquidated damages, if any, associated with the termination.
The Company is routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position or results of operations.

ITEM 1A. Risk Factors.

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

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

Risks Related to Being a Regulated Entity

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

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

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In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act collectively referred to as the Affordable Care Act (ACA), were enacted. While the constitutionality of the ACA was subsequently challenged in a number of legal actions, in June 2012, the Supreme Court upheld the constitutionality of the ACA, with one limited exception relating to the Medicaid expansion provision. The Court held that states could not be required to expand Medicaid and risk losing all federal money for their existing Medicaid programs. Under the ACA, Medicaid coverage will be expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level beginning January 1, 2014, subject to the states' elections. The federal government will pay the entire costs for Medicaid coverage for newly eligible beneficiaries for 3 years, from 2014 through 2016. In 2017, the federal share declines to 95%; in 2018 it is 94%; in 2019 it is 93%; and it will be 90% in 2020 and subsequent years. States may delay Medicaid expansion after 2014 but the federal payment rates will be less. Currently 25 States remain undecided about expanding Medicaid eligibility, although most are involved in a variety of legislative proposals within their States. The U.S. Department of Health and Human Services (HHS) has stated that it will consider a limited number of premium assistance demonstration proposals from States that want to privatize Medicaid expansion. States must provide a choice between at least two qualified health plans and offer very similar benefits as those available in the newly created insurance exchanges.

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

Changes to Medicaid, CHIP, LTC, 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, LTC, 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. It is funded jointly by the federal government and States through a formula based on the Medicaid Federal Medical Assistance Percentage (FMAP). As an incentive for States to expand their coverage programs for children, Congress created an enhanced federal matching rate for CHIP that is about 15 percentage points higher than the Medicaid rate. Every fiscal year the Centers for Medicare & Medicaid Services (CMS) determines the federal share of program funding. 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.

The Affordable Care Act extends CHIP through September 30, 2019. Beginning October 1, 2015, the enhanced CHIP federal matching rate will increase by 23 percentage points, bringing the average federal matching rate for CHIP to 93%. This rate continues until September 30, 2019.

The federal allotment for CHIP for fiscal year 2012 was $14.982 billion.

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.

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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, 2013 and December 31, 2016. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. For example, on April 12, 2010, the Wisconsin Department of Health Services notified us that our Wisconsin subsidiary was not awarded a Southeast Wisconsin BadgerCare Plus Managed Care contract. While we will continue to serve other regions of the state, we transitioned the affected members to other plans by November 1, 2010. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds. For example, the Indiana contract under which we operate can be terminated by the State without cause. Our contracts could also be terminated if we fail to perform in accordance with the standards set by state regulatory agencies. If any of our contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, our business will suffer, and our financial position, results of operations or cash flows may be materially affected.

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

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

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

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

Regulations may decrease the profitability of our health plans.

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

regulatory actions could harm our financial position, results of operations or cash flows. Certain states also impose marketing restrictions on us which may constrain our membership growth and our ability to increase our revenues.

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

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

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

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

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

- cancellation of our contracts;
- refunding of amounts we have been paid pursuant to our contracts;
- imposition of fines, penalties and other sanctions on us;
- loss of our right to participate in various markets;
- increased difficulty in selling our products and services; or
- loss of one or more of our licenses.

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

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

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

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

Many aspects of our business are affected by government laws and regulations. The issuance of new regulations, or judicial or regulatory guidance regarding existing regulations, could require changes to many of the procedures we currently use to conduct our business, which may lead to additional costs that we have not yet identified. We do not know whether, or the extent to which, we will be able to recover from the states our costs of complying with these

new regulations. The costs of any such future compliance efforts could have a material adverse effect on our business. We have already expended significant time, effort and financial resources to comply with the privacy and security requirements of HIPAA and HITECH, and will have to expend additional time and financial resources to comply with the American Recovery and Reinvestment Act of 2009, the Patient Protection and Affordable Care Act and the 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.

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Changes in healthcare law and benefits may reduce our profitability.

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

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

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

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

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

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

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

Our participation in health insurance exchanges, which are required to be established as part of the ACA, could adversely affect our results of operations, financial position and cash flows.
The ACA requires the establishment of health insurance exchanges for individuals and small employers by 2014. There are a number of uncertainties with respect to the establishment of such insurance exchanges, including, but not limited to, the requirements for participation and operations for exchanges in each state, the impact of federal subsidies for premiums and cost-sharing reductions and the operation and funding of various mechanisms intended to manage and spread risk among insurers. Depending on how these factors develop once the health insurance exchanges

are established, the health insurance exchanges could ultimately have a negative impact on our results of operations, financial position or liquidity. In addition, the ACA also requires insurers participating on the health insurance exchanges to offer a minimum level of benefits while including guidelines on setting premium rates and coverage limitations. These factors, along with the limited information that we expect to have about the individuals who will have access to these newly established exchanges may cause our earnings to be affected negatively if our premiums are not adequate or do not appropriately reflect the acuity of these individuals.

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

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

Changes in federal funding mechanisms may reduce our profitability.

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

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

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

The American Taxpayer Relief Act (ATRA) of 2012, known as the fiscal cliff deal, delayed the sequestration mandated under the Sequestration Transparency Act of 2012 until March 1, 2013. Although Medicaid is exempt from cuts under the ATRA, there will be a 2% cut in payments to Medicare providers and suppliers.

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.

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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 Kentucky in November 2011, in Louisiana in February 2012, in Missouri and Washington in July 2012 and expanded in Texas in March 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.

Assumptions and estimates are utilized in establishing premium deficiency reserves. In October 2012, we notified the Kentucky Cabinet for Health and Family Services that we were exercising a contractual right that we believe allows Kentucky Spirit to terminate its Medicaid managed care contract with the Commonwealth of Kentucky effective July 5, 2013. As a result, we recorded a premium deficiency reserve included in Medical costs expense of $41.5 million for the Kentucky contract in the year ended December 31, 2012. The premium deficiency reserve encompasses the contract period from January 1, 2013 through July 5, 2013. If our assumptions are inaccurate, our reserves may be inadequate to pay medical costs and there could be a material adverse effect on the results of operations and financial condition. In addition, if the contract is not terminated effective July 5, 2013, we may be required to increase our premium deficiency reserve and there could be a material adverse effect on the results of operations and financial condition.

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

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

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

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

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

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

As of March 31, 2013, we had $876.9 million in cash, cash equivalents and short-term investments and $787.6 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.

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, 2013, we had $562.0 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.

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

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

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

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

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

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

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

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.

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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 2013 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.

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

Operations in a few states have accounted for most of our premium revenues to date. If we were unable to continue to operate in any of our current states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could

cause our revenue and profitability to change suddenly and unexpectedly depending on legislative or other governmental or regulatory actions and decisions, economic conditions and similar factors in those states. For example, states we currently serve may bid out their Medicaid program through a Request for Proposal, or RFP, process. Our inability to continue to operate in any of the states in which we operate would harm our business.

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

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

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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 canceled 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.

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

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

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

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

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

Less favorable economic conditions may cause our membership to increase as more people become eligible to receive Medicaid benefits. During such economic downturns, however, state and federal budgets could decrease, causing states to attempt to cut healthcare programs, benefits and rates. Additionally, the number of individuals eligible for Medicaid managed care will likely increase as a result of the health care reform legislation. We cannot predict the impact of changes in the United States economic environment or other economic or political events, including acts of terrorism or related military action, on federal or state funding of healthcare programs or on the size of the population eligible for the programs we operate. If federal or state funding decreases or remains unchanged while our membership increases, our results of operations will suffer.

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

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

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

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

membership verifications, claims status and other information.

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

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

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

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

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

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

We are a defendant from time to time in lawsuits and regulatory actions relating to our business. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and financial position, results of operations or cash flows. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and time consuming and require significant attention from our management. For example, we have been named in a recently-filed securities lawsuit seeking class action and we have in the past, or may be subject to in the future, IRS examinations, securities class action lawsuits or similar regulatory actions. Any such matters could harm our business and financial position, results of operations or cash flows.

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

Goodwill and other intangible assets were $275.6 million as of March 31, 2013. We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. Changes in business strategy, government regulations or economic or market conditions have resulted and may result in impairments of our goodwill and other intangible assets at any time in the future. Our judgments regarding the existence of impairment indicators are based on, among other things, legal factors, market conditions, and operational performance. For example, the non-renewal of our health plan contracts with the state in which they operate may be an indicator of impairment.

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

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

As part of our normal operations, we collect, process and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act. The American Recovery and Reinvestment Act of 2009 further expands the coverage of HIPAA by, among other things, extending the privacy and security provisions, requiring new

disclosures if a data breach occurs, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions and increasing penalties for violations. Despite the security measures we have in place to ensure compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, whether by us or a third party, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

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

Issuer Purchases of Equity Securities
First Quarter 2013

Period	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs[2]
January 1 – January 31, 2013	1,866	$42.88	—	1,667,724
February 1 – February 28, 2013	4,137	45.11	—	1,667,724
March 1 – March 31, 2013	6,356	46.97	—	1,667,724
Total	12,359	$45.73	—	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 which allows for repurchases of up to a remaining amount of 1,667,724 shares. No duration has been placed on the repurchase program.

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ITEM 6. Exhibits.

Exhibits.

EXHIBIT NUMBER	DESCRIPTION
10.1[1]	Amendment D (Version 2.4) to the contract between the Texas Health and Human Services Commission and Bankers Reserve Life Insurance Company of Wisconsin, Inc. d.b.a. Superior HealthPlan Network
12.1	Computation of ratio of earnings to fixed charges.
31.1	Certification of Chairman, President and Chief Executive Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Executive Vice President and Chief Financial Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chairman, President and Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Executive Vice President and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.1	XBRL Taxonomy Instance Document.
101.2	XBRL Taxonomy Extension Schema Document.
101.3	XBRL Taxonomy Extension Calculation Linkbase Document.
101.4	XBRL Taxonomy Extension Definition Linkbase Document.
101.5	XBRL Taxonomy Extension Label Linkbase Document.
101.6	XBRL Taxonomy Extension Presentation Linkbase Document.

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

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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 23, 2013.

CENTENE CORPORATION

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

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

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