CENTENE CORP
Form 10-Q
April 28, 2015

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, 2015
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 o 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 o 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 o Non-accelerated filer o (do not check if a smaller reporting company) Smaller reporting company o

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

As of April 17, 2015, the registrant had 118,914,646 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 II, Item 1A. “Risk Factors,” and Part II, Item 1 “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 but not limited to:

- our ability to accurately predict and effectively manage health benefits and other operating expenses and reserves;
- 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, estimated purchase price and accretion for acquisitions;
- inflation;
- foreign currency fluctuations;
- provider and state contract changes;
- new technologies;
- advances in medicine;
- 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;
- the outcome of pending legal proceedings;
- availability of debt and equity financing, on terms that are favorable to us; and
- general economic and market conditions.

This list of important factors is not intended to be exhaustive. We discuss certain of these matters more fully, as well as certain risk factors that may affect our business operations, financial condition and results of operations, in our filings with the Securities and Exchange Commission, including our annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K.

Other Information

The discussion in Part I, Item 2. "Management’s Discussion and Analysis of Financial Condition and Results of Operations" under the heading "Results of Operations" contains financial information for new and existing businesses. Existing businesses are primarily state markets, significant geographic expansion in an existing state or product that we have managed for four complete quarters. New businesses are primarily new state markets, significant geographic expansion in an existing state or product that conversely, we have not managed for four complete quarters.

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Item 1A “Risk Factors” of Part II of this filing contains a further discussion of these and other important factors that could cause actual results to differ from expectations. We disclaim any current intention or obligation to update or revise any forward-looking statements, whether as a result of new information, future events or otherwise. Due to these important factors and risks, we cannot give assurances with respect to our future premium levels or our ability to control our future medical costs.

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PART I
FINANCIAL INFORMATION

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

	March 31, 2015	December 31, 2014
ASSETS		
Current assets:		
Cash and cash equivalents	$1,666	$1,610
Premium and related receivables	1,245	912
Short term investments	151	177
Other current assets	528	335
Total current assets	3,590	3,034
Long term investments	1,527	1,280
Restricted deposits	98	100
Property, software and equipment, net	450	445
Goodwill	786	754
Intangible assets, net	131	120
Other long term assets	114	91
Total assets	$6,696	$5,824
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$1,950	$1,723
Accounts payable and accrued expenses	1,002	768
Return of premium payable	269	236
Unearned revenue	117	168
Current portion of long term debt	5	5
Total current liabilities	3,343	2,900
Long term debt	1,123	874
Other long term liabilities	238	159
Total liabilities	4,704	3,933
Commitments and contingencies		
Redeemable noncontrolling interests	155	148
Stockholders' equity:		
Preferred stock, $0.001 par value; authorized 10,000,000 shares; no shares issued or outstanding at March 31, 2015 and December 31, 2014	—	—
Common stock, $.001 par value; authorized 200,000,000 shares; 124,562,959 issued and 118,886,912 outstanding at March 31, 2015, and 124,274,864 issued and 118,433,416 outstanding at December 31, 2014	—	—
Additional paid-in capital	870	840
Accumulated other comprehensive loss	(1)	(1)
Retained earnings	1,066	1,003
Treasury stock, at cost (5,676,047 and 5,841,448 shares, respectively)	(98)	(98)
Total Centene stockholders' equity	1,837	1,744

Noncontrolling interest	—	(1)
Total stockholders' equity	1,837	1,743
Total liabilities and stockholders' equity	$6,696	$5,824

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 millions, except share data)
(Unaudited)

	Three Months Ended March 31,	
	2015	2014
Revenues:		
Premium	$4,299	$3,071
Service	462	281
Premium and service revenues	4,761	3,352
Premium tax and health insurer fee	370	108
Total revenues	5,131	3,460
Expenses:		
Medical costs	3,861	2,743
Cost of services	402	242
General and administrative expenses	403	296
Premium tax expense	281	78
Health insurer fee expense	55	31
Total operating expenses	5,002	3,390
Earnings from operations	129	70
Other income (expense):		
Investment and other income	9	5
Interest expense	(10)	(7)
Earnings from continuing operations, before income tax expense	128	68
Income tax expense	63	35
Earnings from continuing operations, net of income tax expense	65	33
Discontinued operations, net of income tax expense of $0 and $0, respectively	(1)	(1)
Net earnings	64	32
(Earnings) loss attributable to noncontrolling interests	(1)	1
Net earnings attributable to Centene Corporation	$63	$33
Amounts attributable to Centene Corporation common shareholders:		
Earnings from continuing operations, net of income tax expense	$64	$34
Discontinued operations, net of income tax expense (benefit)	(1)	(1)
Net earnings	$63	$33
Net earnings (loss) per common share attributable to Centene Corporation:		
Basic:		
Continuing operations	$0.54	$0.30
Discontinued operations	(0.01)	(0.01)
Basic earnings per common share	$0.53	$0.29
Diluted:		
Continuing operations	$0.52	$0.29
Discontinued operations	(0.01)	(0.01)
Diluted earnings per common share	$0.51	$0.28
Weighted average number of common shares outstanding:		
Basic	118,783,755	114,967,752

Diluted	122,572,366	118,722,532

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 millions)
(Unaudited)

	Three Months Ended March 31,	
	2015	2014
Net earnings	$64	$32
Change in unrealized gain on investments, net of tax	5	2
Foreign currency translation adjustments	(5)	—
Other comprehensive earnings	—	2
Comprehensive earnings	64	34
Comprehensive (earnings) loss attributable to noncontrolling interests	(1)	1
Comprehensive earnings attributable to Centene Corporation	$63	$35

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 millions, except share data)
(Unaudited)

Three Months Ended March 31, 2015

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	$.001 Par Value Shares	Amt	Non controlling Interest	Total
Balance, December 31, 2014	124,274,864	$—	$ 840	$ (1)	$ 1,003	5,841,448	$(98)	$ (1)	$1,743
Comprehensive Earnings:									
Net earnings	—	—	—	—	63	—	—	—	63
Change in unrealized investment loss, net of $3 tax	—	—	—	5	—	—	—	—	5
Foreign currency translation	—	—	—	(5)	—	—	—	—	(5)
Total comprehensive earnings									63
Common stock issued for acquisition	—	—	9	—	—	(247,580)	4	—	13
Common stock issued for employee benefit plans	288,095	—	2	—	—	—	—	—	2
Common stock repurchases	—	—	—	—	—	82,179	(4)	—	(4)
Stock compensation expense	—	—	16	—	—	—	—	—	16
Excess tax benefits from stock compensation	—	—	3	—	—	—	—	—	3
Reclassification to redeemable noncontrolling interest	—	—	—	—	—	—	—	1	1
Balance, March 31, 2015	124,562,959	$—	$ 870	$ (1)	$ 1,066	5,676,047	$(98)	$ —	$1,837

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 millions)
(Unaudited)

	Three Months Ended March 31,	
	2015	2014
Cash flows from operating activities:		
Net earnings	$64	$32
Adjustments to reconcile net earnings to net cash provided by operating activities		
Depreciation and amortization	27	20
Stock compensation expense	16	11
Deferred income taxes	(6)	(8)
Gain on settlement of contingent consideration	(10)	—
Changes in assets and liabilities		
Premium and related receivables	(334)	(119)
Other current assets	(3)	3
Other assets	(13)	(14)
Medical claims liabilities	227	196
Unearned revenue	(51)	35
Accounts payable and accrued expenses	58	91
Other long term liabilities	68	4
Other operating activities	2	1
Net cash provided by operating activities	45	252
Cash flows from investing activities:		
Capital expenditures	(27)	(18)
Purchases of investments	(307)	(167)
Sales and maturities of investments	111	112
Proceeds from asset sale	7	—
Investments in acquisitions, net of cash acquired	(9)	(77)
Net cash used in investing activities	(225)	(150)
Cash flows from financing activities:		
Proceeds from exercise of stock options	2	2
Proceeds from borrowings	500	645
Payment of long term debt	(253)	(519)
Excess tax benefits from stock compensation	3	—
Common stock repurchases	(4)	(2)
Contribution from noncontrolling interest	—	5
Debt issue costs	(4)	—
Payment of contingent consideration obligation	(8)	—
Net cash provided by financing activities	236	131
Net increase in cash and cash equivalents	56	233
Cash and cash equivalents, beginning of period	1,610	1,038
Cash and cash equivalents, end of period	$1,666	$1,271
Supplemental disclosures of cash flow information:		
Interest paid	$2	$2
Income taxes paid	$24	$21
Equity issued in connection with acquisitions	$13	$132

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 millions, except share data)
(Unaudited)

1. Basis of Presentation

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, 2014. 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, 2014 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 2014 amounts in the notes to the consolidated financial statements have been reclassified to conform to the 2015 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

On February 2, 2015, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed February 19, 2015 to stockholders of record on February 12, 2015. All share and per share information presented in this Form 10-Q has been adjusted for the two-for-one stock split.

Recently Adopted Accounting Pronouncement

In April 2015, the Financial Accounting Standards Board (FASB) issued an Accounting Standards Update which changes the presentation of debt issuance costs in financial statements. Under the new standard, debt issuance costs are presented in the balance sheet as a direct deduction of the related debt liability rather than as an asset. Amortization of the cost is reported as interest expense. The new standard is effective for annual and interim periods beginning after December 15, 2015 and early adoption is permitted. The Company has elected to adopt this guidance in the current fiscal quarter and applied the new standard retrospectively to all prior periods. The reclassification of debt issuance costs impacted the Consolidated Balance Sheets by decreasing both Other Long Term Assets and Long Term Debt by $14 million at December 31, 2014 and $17 million at March 31, 2015. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

2. Acquisitions and Redeemable Noncontrolling Interest

Acquisitions

Community Health Solutions of America, Inc.

In July 2014, the Company completed a transaction whereby Community Health Solutions of America, Inc. assigned its contract with the Louisiana Department of Health and Hospitals under the Bayou Health Shared Savings Program to the Company's subsidiary, Louisiana Healthcare Connections (LHC). The fair value of consideration transferred included the present value of the estimated contingent consideration, subject to membership retained by LHC in the first quarter of 2015. The fair value of contingent consideration was $18 million at December 31, 2014. During the three months ended March 31, 2015, the Company determined the amount of the actual contingent consideration to be

$8 million. A gain of $10 million related to the settlement of the obligation was recorded in General and Administrative expense.

LiveHealthier, Inc.

In January 2015, the Company acquired the remaining 79% of LiveHealthier, Inc. (LiveHealthier) for $28 million, bringing its total ownership to 100%. LiveHealthier is a provider of technology and service-based health management solutions. The fair value of consideration of $28 million consists of cash paid of $11 million, Centene common stock issued at closing of $13 million, and the present value of contingent consideration of $4 million to be paid in cash over a three year period. The contingent consideration will not exceed $9 million.

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The Company's preliminary allocation of fair value resulted in goodwill of $29 million and other identifiable intangible assets of $16 million. The Company has not finalized the allocation of the fair value of assets and liabilities. The goodwill is not deductible for income tax purposes. The acquisition is recorded in the Managed Care segment.

Redeemable Noncontrolling Interest

In January 2015, the Company sold 25% of its ownership in Celtic Insurance Company for $7 million. No gain or loss was recognized on the sale of the ownership interest. Celtic Insurance Company is included in the Managed Care segment. In connection with the sale of the ownership interest, the Company entered into a put agreement with the noncontrolling interest holder, allowing the noncontrolling interest holder to put its interest back to the Company beginning in 2022. As a result of put option agreements, noncontrolling interest is considered redeemable and is classified in the Redeemable Noncontrolling Interest section of the consolidated balance sheets.

A reconciliation of the changes in the Redeemable Noncontrolling Interests is as follows ($ in millions):

Balance, December 31, 2014	$148
Fair value of redeemable noncontrolling interest sold	7
Reclassification to redeemable noncontrolling interest	(1)
Net earnings attributable to redeemable noncontrolling interests	1
Balance, March 31, 2015	$155

3. Short term and Long term Investments, Restricted Deposits

Short term and long term investments and restricted deposits by investment type consist of the following ($ in millions):

	March 31, 2015				December 31, 2014			
	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	$451	$2	$(1)	$452	$393	$1	$(2)	$392
Corporate securities	618	4	(1)	621	556	2	(2)	556
Restricted certificates of deposit	6	—	—	6	6	—	—	6
Restricted cash equivalents	77	—	—	77	79	—	—	79
Municipal securities:								
General obligation	97	1	—	98	54	—	—	54
Pre-refunded	4	—	—	4	5	—	—	5
Revenue	158	—	—	158	101	1	—	102
Variable rate demand notes	27	—	—	27	14	—	—	14
Asset backed securities	170	—	—	170	180	—	—	180
Mortgage backed securities	81	2	—	83	84	1	—	85
Cost and equity method investments	64	—	—	64	68	—	—	68
Life insurance contracts	16	—	—	16	16	—	—	16
Total	$1,769	$9	$(2)	$1,776	$1,556	$5	$(4)	$1,557

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The Company's investments are classified as available-for-sale with the exception of life insurance contracts and certain cost and equity method investments. The Company's investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets with the focus on high credit quality securities. The Company limits the size of investment in any single issuer other than U.S. treasury securities and obligations of U.S. government corporations and agencies. The Company's mortgage backed securities are issued by the Federal National Mortgage Association and carry guarantees by the U.S. government. As of March 31, 2015, 47% 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, 66% were rated AA-/Aa3 or higher, and 91% were rated A-/A3 or higher. At March 31, 2015, the Company held certificates of deposit, life insurance contracts and cost and equity method investments which did not carry a credit rating.

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

	March 31, 2015				December 31, 2014			
	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	$(1)	$80	$—	$16	$—	$72	$(2)	$180
Corporate securities	(1)	185	—	1	(2)	311	—	1
Municipal securities:								
General obligation	—	22	—	4	—	4	—	3
Revenue	—	72	—	3	—	16	—	3
Pre-refunded	—	—	—	—	—	—	—	1
Asset backed securities	—	40	—	10	—	70	—	10
Mortgage backed securities	—	—	—	—	—	18	—	—
Total	$(2)	$399	$—	$34	$(2)	$491	$(2)	$198

As of March 31, 2015, the gross unrealized losses were generated from 90 positions out of a total of 363 positions. The change 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.

During the quarter ended March 31, 2015, the company recognized $1 million of income from equity method investments.

The contractual maturities of short term and long term investments and restricted deposits are as follows ($ in millions):

	March 31, 2015				December 31, 2014			
	Investments		Restricted Deposits		Investments		Restricted Deposits	
	Amortized	Fair	Amortized	Fair	Amortized	Fair	Amortized	Fair

	Cost	Value	Cost	Value	Cost	Value	Cost	Value
One year or less	$151	$151	$90	$90	$176	$177	$92	$92
One year through five years	1,316	1,322	8	8	1,121	1,121	8	8
Five years through ten years	120	120	—	—	121	120	—	—
Greater than ten years	84	85	—	—	38	39	—	—
Total	$1,671	$1,678	$98	$98	$1,456	$1,457	$100	$100

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Actual maturities may differ from contractual maturities due to call or prepayment options. Asset backed and mortgage 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.

4. Fair Value Measurements

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

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

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The following table summarizes fair value measurements by level at March 31, 2015, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$1,666	$—	$—	$1,666
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$434	$3	$—	$437
Corporate securities	—	621	—	621
Municipal securities:				
General obligation	—	98	—	98
Pre-refunded	—	4	—	4
Revenue	—	158	—	158
Variable rate demand notes	—	27	—	27
Asset backed securities	—	170	—	170
Mortgage backed securities	—	83	—	83
Total investments	$434	$1,164	$—	$1,598
Restricted deposits available for sale:				
Cash and cash equivalents	$77	$—	$—	$77
Certificates of deposit	6	—	—	6
U.S. Treasury securities and obligations of U.S. government corporations and agencies	15	—	—	15
Total restricted deposits	$98	$—	$—	$98
Other long term assets: Interest rate swap agreements	$—	$16	$—	$16
Total assets at fair value	$2,198	$1,180	$—	$3,378
Liabilities				
Other long term liabilities:				
Interest rate swap agreements	$—	$2	$—	$2
Total liabilities at fair value	$—	$2	$—	$2

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The following table summarizes fair value measurements by level at December 31, 2014, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$1,610	$—	$—	$1,610
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$360	$17	$—	$377
Corporate securities	—	556	—	556
Municipal securities:				
General obligation	—	54	—	54
Pre-refunded	—	5	—	5
Revenue	—	102	—	102
Variable rate demand notes	—	14	—	14
Asset backed securities	—	180	—	180
Mortgage backed securities	—	85	—	85
Total investments	$360	$1,013	$—	$1,373
Restricted deposits available for sale:				
Cash and cash equivalents	$79	$—	$—	$79
Certificates of deposit	6	—	—	6
U.S. Treasury securities and obligations of U.S. government corporations and agencies	15	—	—	15
Total restricted deposits	$100	$—	$—	$100
Other long term assets: Interest rate swap agreements	$—	$11	$—	$11
Total assets at fair value	$2,070	$1,024	$—	$3,094

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, 2015, there were less than $1 million of transfers from Level I to Level II and $14 million 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 $80 million and $84 million as of March 31, 2015 and December 31, 2014, respectively.

5. Health Insurance Marketplace

The Affordable Care Act (ACA) established risk spreading premium stabilization programs effective January 1, 2014 for the Health Insurance Marketplace product. These programs, commonly referred to as the "three Rs," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. Additionally, the ACA established a minimum annual medical loss ratio for the Health Insurance Marketplace. Each of the three R programs are taken into consideration to determine if the Company's estimated annual medical costs are less than the minimum loss ratio and require an adjustment to Premium revenue to meet the minimum medical loss ratio.

The Company's receivables (payables) for each of these programs are as follows ($ in millions):

	March 31, 2015	December 31, 2014
Risk adjustment	$(72)	$(44)

Reinsurance	15	11
Risk corridor	(23)	(9)
Minimum medical loss ratio	(16)	(6)

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6. Debt

Debt consists of the following ($ in millions):

	March 31, 2015	December 31, 2014
$425 million 5.75% Senior notes, due June 1, 2017	$429	$429
$500 million 4.75% Senior notes, due May 15, 2022	500	300
Fair value of interest rate swap agreements	14	11
Senior notes	943	740
Revolving credit agreement	125	75
Mortgage notes payable	69	70
Capital leases	8	8
Debt issuance costs	(17)	(14)
Total debt	1,128	879
Less current portion	(5)	(5)
Long term debt	$1,123	$874

Senior Notes

In January 2015, the Company issued an additional $200 million of 4.75% Senior Notes ($200 Million Add-on Notes) at par. The $200 million Add-on Notes were offered as additional debt securities under the indenture governing the $300 Million of 4.75% Senior Notes issued in April 2014. In connection with the January 2015 issuance, the Company entered into interest rate swap agreements for a notional amount of $200 million at a floating rate of interest based on the three month LIBOR plus 2.88%. 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 $200 Million Add-on Notes.

The indentures governing both the $425 million notes due 2017 and the $500 million notes due 2022 contain non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio.

Interest Rate Swaps

The Company uses interest rate swap agreements to convert a portion of its interest rate exposure from fixed rates to floating rates to more closely align interest expense with interest income received on its cash equivalent and variable rate investment balances. The Company has $750 million of notional amount of interest rate swap agreements consisting of $250 million which are scheduled to expire on June 1, 2017 and $500 million that are scheduled to expire May 15, 2022. Under the Swap Agreements, the Company receives a fixed rate of interest and pays an average variable rate of the three month LIBOR plus 2.85% adjusted quarterly. At March 31, 2015, the weighted average rate was 3.10%.

The Swap Agreements are formally designated and qualify as fair value hedges and are recorded at fair value in the Consolidated Balance Sheet in other assets or other liabilities. Gains and losses due to changes in fair value of the interest rate swap agreements completely offset changes in the fair value of the hedged portion of the underlying debt. Therefore, no gain or loss has been recognized due to hedge ineffectiveness. Offsetting changes in fair value of both the interest rate swaps and the hedged portion of the underlying debt both were recognized in interest expense in the Consolidated Statement of Operations. The Company does not hold or issue any derivative instrument for trading or speculative purposes.

Revolving Credit Agreement

The Company has an unsecured $500 million revolving credit facility. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement has a maturity date of June 1, 2018, provided it will mature 90 days prior to the maturity date of the Company's 5.75% Senior Notes due 2017 if such notes are not refinanced (or extended), certain financial conditions are not met, or the Company does not carry $100 million of unrestricted cash. As of March 31, 2015, the Company had $125 million of borrowings outstanding under the agreement with a weighted average interest rate of 2.51%.

The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. The Company is required to not exceed a maximum debt-to-EBITDA ratio of 3.0 to 1.0. As of March 31, 2015, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

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Letters of Credit & Surety Bonds

The Company had outstanding letters of credit of $30 million as of March 31, 2015, which were not part of the revolving credit facility. The Company also had letters of credit for $52 million (valued at March 31, 2015 conversion rate), or €48 million, representing its proportional share of the letters of credit issued to support Ribera Salud's outstanding debt which are a part of the revolving credit facility. Collectively, the letters of credit bore interest at 1.73% as of March 31, 2015. The Company had outstanding surety bonds of $196 million as of March 31, 2015.

7. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per common share ($ in millions, except per share data):

	Three Months Ended March 31,	
	2015	2014
Earnings attributable to Centene Corporation:		
Earnings from continuing operations, net of tax	$64	$34
Discontinued operations, net of tax	(1)	(1)
Net earnings	$63	$33
Shares used in computing per share amounts:		
Weighted average number of common shares outstanding	118,783,755	114,967,752
Common stock equivalents (as determined by applying the treasury stock method)	3,788,611	3,754,780
Weighted average number of common shares and potential dilutive common shares outstanding	122,572,366	118,722,532
Net earnings (loss) per common share attributable to Centene Corporation:		
Basic:		
Continuing operations	$0.54	$0.30
Discontinued operations	(0.01)	(0.01)
Basic earnings per common share	$0.53	$0.29
Diluted:		
Continuing operations	$0.52	$0.29
Discontinued operations	(0.01)	(0.01)
Diluted earnings per common share	$0.51	$0.28

The calculation of diluted earnings per common share for the three months ended March 31, 2015 and 2014 excludes the impact of 26,376 shares and 45,912 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

8. Segment Information

Centene operates in two segments: Managed Care and Specialty Services. The 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 auxiliary healthcare services and products.

Segment information for the three months ended March 31, 2015, follows ($ in millions):

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	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$4,243	$518	$—	$4,761
Premium and service revenues from internal customers	24	1,075	(1,099)	—
Total premium and service revenues	$4,267	$1,593	$(1,099)	$4,761
Earnings from operations	$95	$34	$—	$129

Segment information for the three months ended March 31, 2014, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$2,970	$382	$—	$3,352
Premium and service revenues from internal customers	13	639	(652)	—
Total premium and service revenues	$2,983	$1,021	$(652)	$3,352
Earnings from operations	$44	$26	$—	$70

9. Contingencies

On July 5, 2013, the Company's subsidiary, Kentucky Spirit Health Plan, Inc. (Kentucky Spirit), terminated its contract with the Commonwealth of Kentucky (the Commonwealth). Kentucky Spirit believes it had a contractual right to terminate the contract and filed a lawsuit in Franklin Circuit Court seeking a declaration of this right. The Commonwealth has alleged that Kentucky Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25 million performance bond. The Commonwealth's attorneys have asserted that the Commonwealth's expenditures due to Kentucky Spirit's departure range from $28 million to $40 million plus interest, and that the associated CMS expenditures range from $92 million to $134 million. Kentucky Spirit disputes the Commonwealth's alleged damages, and is pursuing its own litigation claims for damages against the Commonwealth.

On February 6, 2015, the Kentucky Court of Appeals affirmed a Franklin Circuit Court ruling that Kentucky Spirit does not have a contractual right to terminate the contract early. The Court of Appeals also found that the contract’s liquidated damages provision “is applicable in the event of a premature termination of the Contract term.” Kentucky Spirit intends to seek Kentucky Supreme Court review of the finding that its departure constituted a breach of contract. The Commonwealth may seek review of the ruling that the liquidated damages provision is applicable in the event of a premature termination.

Kentucky Spirit also filed a lawsuit in April 2013, amended in October 2014, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches. On December 9, 2014, the Franklin Circuit Court denied the Commonwealth's motion for partial summary judgment on Kentucky Spirit's damages claims. On March 15, 2015, the Franklin Circuit Court denied the Commonwealth's motion to stay discovery and ordered that discovery proceed on those claims.

On March 9, 2015, the Secretary of the Kentucky Cabinet for Health and Family Services (CHFS) issued a determination letter finding that Kentucky Spirit owed the Commonwealth $40 million in actual damages plus prejudgment interest at 8 percent. On March 18, 2015, in a letter to the Kentucky Finance and Administration Cabinet, Kentucky Spirit contested CHFS' jurisdiction to make such a determination. Depending on the response from the Finance and Administration Cabinet, Kentucky Spirit may bring the matter to the Franklin Circuit Court.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If Kentucky Spirit prevails on its claims, it would be entitled to damages. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. The Company is unable to estimate the ultimate outcome resulting from the Kentucky litigation. As a result, the Company has not recorded any receivable or any liability for potential damages under the contract as of March 31, 2015. While uncertain, the ultimate resolution of the pending litigation could have a material effect on the financial position, cash flow or results of operations of the Company in the period it is resolved or becomes known.

Excluding the Kentucky matters discussed above, the Company is also routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters in the normal course of business 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, results of operations or cash flows.

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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 known and unknown risks and uncertainties, including those set forth under Part II, Item 1A. “Risk Factors” of this Form 10-Q.

OVERVIEW

In 2013, we classified the operations for Kentucky Spirit Health Plan (KSHP) as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise identified.

On February 2, 2015, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed February 19, 2015 to stockholders of record on February 12, 2015. All share and per share information presented in this Form 10-Q has been adjusted for the two-for-one stock split.

Key financial metrics for the first quarter of 2015 are summarized as follows:

- Quarter-end managed care membership of 4.4 million, an increase of 1.4 million members, or 44% year over year.
- Premium and service revenues of $4.8 billion, representing 42% growth year over year.
- Health Benefits Ratio of 89.8%, compared to 89.3% in 2014.
- General and Administrative expense ratio of 8.5%, compared to 8.8% in 2014.
- Operating cash flows of $45 million for the first quarter of 2015.
- Diluted net earnings per share of $0.52, compared to $0.29 in 2014.

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

- Florida. In May 2014, our Florida subsidiary, Sunshine Health, began operating under a new contract in 9 of 11 regions of the Managed Medical Assistance (MMA) program. The MMA program includes TANF recipients as well as ABD and dual-eligible members. In addition, we began operating as the sole provider under a new statewide contract for the Child Welfare Specialty Plan (Foster Care). Enrollment for both the MMA program and Foster Care began in May 2014 and was implemented by region through August 2014.

- Health Insurance Marketplaces (HIM). In January 2015, we expanded our participation in Health Insurance Marketplaces to include members in certain regions of Illinois and Wisconsin.

- Illinois. In March 2014, our Illinois subsidiary, IlliniCare Health, began operating under a new contract as part of the Illinois Medicare-Medicaid Alignment Initiative serving dual-eligible members in Cook, DuPage, Lake, Kane, Kankakee and Will counties (Greater Chicago region).

In July 2014, IlliniCare Health began operating under a new contract with the Cook County Health and Hospitals System to perform third party administrative services to members enrolled in the CountyCare program, as well as care coordination, behavioral health, vision care and pharmacy benefit management services.

In September 2014, IlliniCare Health began serving additional Medicaid members under the state's Medicaid and Medicaid expansion programs.

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Indiana. In February 2015, our Indiana subsidiary, Managed Health Services, began operating under an expanded contract with the Indiana Family & Social Services Administration to provide Medicaid services under the state's Healthy Indiana Plan 2.0 program.

- Louisiana. In July 2014, we completed the transaction whereby Community Health Solutions of America, Inc. (CHS) assigned its contract with the Louisiana Department of Health and Hospitals under the Bayou Health Shared Savings Program to our subsidiary, Louisiana Healthcare Connections (LHC).

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In February 2015, LHC began operating under a new contract with the Louisiana Department of Health and Hospitals to serve Bayou Health (Medicaid) beneficiaries. Members previously served under the shared savings program were transitioned to the at-risk program on February 1, 2015.

- Mississippi. In July 2014, our Mississippi subsidiary, Magnolia Health, began operating as one of two contractors under a new statewide managed care contract serving members enrolled in the Mississippi Coordinated Access Network program. Program expansion began in December 2014.

In January 2015, Magnolia Health began operating under a new contract with the State of Mississippi to provide services under the Children's Health Insurance Program (CHIP).

- New Hampshire. In September 2014, our New Hampshire subsidiary, New Hampshire Healthy Families, began serving members under the state's Medicaid expansion program.

- Ohio. In May 2014, our Ohio subsidiary, Buckeye Health Plan (Buckeye), began operating under a new contract with the Ohio Department of Medicaid and the Centers for Medicare and Medicaid Services to serve Medicaid members in a dual-eligible demonstration program in three of seven regions: Northeast (Cleveland), Northwest (Toledo) and West Central (Dayton). This three-year program, which is part of the Integrated Care Delivery System expansion, serves those who have both Medicare and Medicaid eligibility. Passive enrollment for Medicaid began in May 2014 and implementation was completed in July 2014. Passive enrollment for Medicare began in January 2015.

- South Carolina. In February 2015, our South Carolina subsidiary, Absolute Total Care, began operating under a new contract with the South Carolina Department of Health and Human Services and the Centers for Medicare and Medicaid Services to serve dual-eligible members as part of the state's dual demonstration program.

- Texas. In September 2014, we began operating under a new contract with the Texas Health and Human Services Commission (HHSC) to expand our operations and serve STAR+PLUS members in two Medicaid Rural Service Areas. We also began providing expanded coverage in September 2014 under our STAR+PLUS contracts to provide acute care services for intellectually and developmentally disabled members. In March 2015, we began operating under an expanded STAR+PLUS contract with the Texas HHSC to include nursing facility benefits.

In March 2015, we also began operating under a new contract with the Texas HHSC and the Centers for Medicare and Medicaid Services to serve dual-eligible members in three counties as part of the state's dual demonstration program.

- Vermont. In February 2015, Centurion began operating under a new contract with the State of Vermont Department of Corrections to provide comprehensive correctional healthcare services.

In addition, in July 2014, we completed an investment accounted for under the equity method for the purchase of a noncontrolling interest in Ribera Salud S.A. (Ribera Salud), a Spanish health management group. Centene is a joint shareholder with Ribera Salud's remaining investor, Banco Sabadell S.A.

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

- We expect to realize the full year benefit in 2015 of business commenced during 2014 in Florida, Illinois, Louisiana, Mississippi, New Hampshire, Ohio and Texas as discussed above.

- In April 2015, Managed Health Services began operating under an expanded contract with the Indiana Family & Social Services Administration to provide services to its ABD Medicaid enrollees who qualify for the new Hoosier

Care Connect Program.

- In April 2015, Centurion was recommended for an award by the Mississippi Department of Corrections to provide comprehensive correctional healthcare services. The contract is expected to commence in the third quarter of 2015.

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- In March 2015, our Missouri subsidiary, Home State Health, was selected by the Missouri Division of Purchasing and Materials Management to continue providing managed care services to MO HealthNet Managed Care beneficiaries. The new contract will be effective in the third quarter of 2015.

- In February 2015, our Texas subsidiary, Superior HealthPlan, was tentatively recommended for a contract award by the Texas HHSC to continue to serve STAR Health (Foster Care) Medicaid recipients. The new contract is expected to commence in the third quarter of 2015.

- In January 2015, we signed a definitive agreement to acquire Agate Resources, Inc., a diversified holding company that offers primarily Medicaid and other healthcare products and services to Oregon residents. The transaction is expected to close in the third quarter of 2015, subject to customary closing conditions, including Oregon regulatory approval.

- In December 2014, our subsidiary, Cenpatico Integrated Care, in partnership with University of Arizona Health Plan, was selected by the Arizona Department of Health Services/Division of Behavioral Health Services to be the Regional Behavioral Health Authority for the new southern geographic service area. The new contract is expected to commence in the fourth quarter of 2015.

- In December 2013, we signed a definitive agreement to purchase a majority stake in Fidelis SecureCare of Michigan, Inc. (Fidelis), a subsidiary of Fidelis SeniorCare, Inc. The transaction is expected to close in the second quarter of 2015, subject to certain closing conditions including regulatory approvals. Fidelis was selected by the Michigan Department of Community Health to provide integrated healthcare services to members who are dually eligible for Medicare and Medicaid in Macomb and Wayne counties. Enrollment is expected to commence in the second quarter of 2015.

MEMBERSHIP

From March 31, 2014 to March 31, 2015, we increased our managed care membership by 1.4 million, or 44%. The following table sets forth our membership by state for our managed care organizations:

	March 31, 2015	December 31, 2014	March 31, 2014
Arizona	202,200	204,000	169,800
Arkansas	43,200	38,400	16,400
California	171,200	163,900	118,100
Florida	463,100	425,700	230,300
Georgia	405,600	389,100	331,400
Illinois	184,800	87,800	22,400
Indiana	227,700	197,700	198,700
Kansas	143,700	143,300	145,000
Louisiana	359,500	152,900	149,800
Massachusetts	64,500	48,400	50,800
Minnesota	9,500	9,500	9,400
Mississippi	141,900	108,700	85,400
Missouri	75,600	71,000	58,100
New Hampshire	67,500	62,700	37,100
Ohio	296,000	280,100	181,800
South Carolina	106,000	109,700	96,300
Tennessee	20,800	21,000	21,100
Texas	974,900	971,000	904,000

Vermont	1,600	—	—
Washington	207,100	194,400	151,700
Wisconsin	82,100	83,200	70,800
Total at-risk membership	4,248,500	3,762,500	3,048,400
Non-risk membership	153,200	298,400	—
Total	4,401,700	4,060,900	3,048,400

At March 31, 2015, we served 331,800 Medicaid members in Medicaid expansion programs in California, Illinois, Indiana, Massachusetts, New Hampshire, Ohio and Washington included in the table above.

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

	March 31, 2015	December 31, 2014	March 31, 2014
Medicaid	3,133,900	2,754,900	2,169,100
CHIP & Foster Care	233,600	222,700	269,200
ABD, Medicare & Duals	410,400	392,700	300,500
LTC	71,200	60,800	51,800
Health Insurance Marketplaces	161,700	74,500	39,700
Hybrid Programs [1]	—	18,900	14,400
Behavioral Health	195,100	197,000	162,700
Correctional Healthcare Services	42,600	41,000	41,000
Total at-risk membership	4,248,500	3,762,500	3,048,400
Non-risk membership	153,200	298,400	—
Total	4,401,700	4,060,900	3,048,400

[1] In February 2015, hybrid programs in Indiana and Massachusetts were converted to Medicaid expansion contracts.

The following table identifies our dual-eligible membership by line of business. The membership tables above include these members.

	March 31, 2015	December 31, 2014	March 31, 2014
ABD	112,600	118,300	72,800
LTC	52,000	35,900	41,300
Medicare	6,800	7,200	6,500
Medicaid / Medicare Duals	12,600	3,200	—
Total	184,000	164,600	120,600

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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, 2015 and 2014, prepared in accordance with generally accepted accounting principles in the United States.

Summarized comparative financial data for the three months ended March 31, 2015 and 2014 is as follows ($ in millions, except per share data):

	Three Months Ended March 31,			
	2015	2014	% Change 2014-2015	
Premium	$4,299	$3,071	40.0	%
Service	462	281	64.4	%
Premium and service revenues	4,761	3,352	42.0	%
Premium tax and health insurer fee	370	108	242.6	%
Total revenues	5,131	3,460	48.3	%
Medical costs	3,861	2,743	40.8	%
Cost of services	402	242	66.1	%
General and administrative expenses	403	296	36.1	%
Premium tax expense	281	78	260.3	%
Health insurer fee expense	55	31	77.4	%
Earnings from operations	129	70	84.3	%
Other income (expense), net	(1)	(2)	50.0	%
Earnings from continuing operations, before income tax expense	128	68	88.2	%
Income tax expense	63	35	80.0	%
Earnings from continuing operations, net of income tax	65	33	97.0	%
Discontinued operations, net of income tax expense of $0 and $0, respectively	(1)	(1)	—	%
Net earnings	64	32	100.0	%
(Earnings) loss attributable to noncontrolling interests	(1)	1	200.0	%
Net earnings attributable to Centene Corporation	$63	$33	90.9	%
Amounts attributable to Centene Corporation common shareholders:				
Earnings from continuing operations, net of income tax expense	$64	$34	88.2	%
Discontinued operations, net of income tax expense	(1)	(1)	—	%
Net earnings	$63	$33	90.9	%
Diluted earnings (loss) per common share attributable to Centene Corporation:				
Continuing operations	$0.52	$0.29	79.3	%
Discontinued operations	(0.01)	(0.01)	—	%
Total diluted earnings per common share	$0.51	$0.28	82.1	%

Three Months Ended March 31, 2015 Compared to Three Months Ended March 31, 2014

Premium and Service Revenues

Premium and service revenues increased 42.0% in the three months ended March 31, 2015 over the corresponding period in 2014 primarily as a result of a full quarter's impact from expansions or new programs in 2014 in many of our states, particularly Florida, Illinois and Ohio. During the three months ended March 31, 2015, we received premium

rate adjustments which yielded a net 0% composite change across all of our markets.

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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 Tax and Health Insurer Fee revenues) 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,:

	2015		2014	
Medicaid, CHIP, Foster Care & HIM	87.6	%	86.9	%
ABD, LTC and Medicare	92.9		92.9	
Specialty Services	85.2		87.7	
Total	89.8		89.3	

The consolidated HBR for the three months ended March 31, 2015, was 89.8%, compared to 89.3% in the same period in 2014. The increase compared to last year is primarily attributable to an increase in higher acuity membership and higher flu related costs over the prior year.

Revenue and HBR results for new business and existing business are listed below to assist in understanding our results of operations. Existing businesses are primarily state markets or significant geographic expansion in an existing state or product that we have managed for four complete quarters. New businesses are primarily new state markets or significant geographic expansion in an existing state or product that conversely, we have not managed for four complete quarters. The following table compares the results for new business and existing business for the three months ended March 31,:

	2015		2014	
Premium and Service Revenue				
New business	23	%	20	%
Existing business	77	%	80	%
HBR				
New business	91.0	%	93.1	%
Existing business	89.5	%	88.3	%

Cost of Services

Cost of services increased by $160 million in the three months ended March 31, 2015, compared to the corresponding period in 2014. This was primarily due to the growth in the AcariaHealth business.

General & Administrative Expenses

General and administrative expenses, or G&A, increased by $107 million in the three months ended March 31, 2015, compared to the corresponding period in 2014. This was primarily due to expenses for additional staff and facilities to support our membership growth. During the three months ended March 31, 2015, we recorded a gain of $10 million on the settlement of contingent consideration related to the CHS transaction. We also recorded expense of $10 million for a contribution to our charitable foundation during the first quarter of 2015.

The consolidated G&A expense ratio for the three months ended March 31, 2015 and 2014 was 8.5% and 8.8%, respectively. The year over year decrease in the G&A ratio reflects the leveraging of expenses over higher revenues

in 2015 as well as the impact of transaction costs recognized in 2014.

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Health Insurer Fee

During the three months ended March 31, 2015, we recorded $55 million of non-deductible expense for the Affordable Care Act (ACA) annual health insurer fee. As of March 31, 2015, we have received signed agreements from all applicable states which provide for the reimbursement of the ACA insurer fee including the related gross-up for the associated income tax effects. As a result, we recorded $88 million in Premium Tax and Health Insurer Fee revenue associated with the accrual for the reimbursement of the fee. Therefore, the health insurer fee had no impact on diluted earnings per share during the first quarter of 2015.

During the three months ended March 31, 2014, we recorded $31 million of non-deductible expense for the ACA annual health insurer fee. In addition, we received signed agreements from 13 of 17 applicable states as of March 31, 2014, which provide for the reimbursement of the ACA insurer fee including the related gross-up for the associated income tax effects (representing approximately 60% of the necessary reimbursements). As a result, we recorded $29 million of revenue in Premium Tax and Health Insurer Fee revenue associated with the accrual for the reimbursement of the fee. The net effect of the health insurer fee reduced our diluted earnings per share by $0.08 during the first quarter of 2014 due to the timing of the recognition of the revenue associated with the reimbursement from our state customers.

Other Income (Expense)

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

	2015	2014
Investment and other income	$9	$5
Interest expense	(10)	(7)
Other income (expense), net	$(1)	$(2)

The increase in investment income in 2015 reflects an increase in investment balances over 2014 and improved performance of certain equity investments. Interest expense increased in 2015 compared to 2014, primarily reflecting the issuance of $300 million of Senior Notes in April 2014 and the issuance of an additional $200 million in Senior Notes in January 2015.

Income Tax Expense

Our effective tax rate for the three months ended March 31, 2015 and 2014, was 49.2% and 51.5%, respectively. The effective tax rate is higher than the applicable statutory rate primarily as a result of the non-deductibility of the health insurer fee expense.

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Segment Results

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

	2015	2014	% Change 2014-2015
Premium and Service Revenues			
Managed Care	$4,267	$2,983	43.0 %
Specialty Services	1,593	1,021	56.0 %
Eliminations	(1,099)	(652)	(68.6)%
Consolidated Total	$4,761	$3,352	42.0 %
Earnings from Operations			
Managed Care	$95	$44	115.9 %
Specialty Services	34	26	30.8 %
Consolidated Total	$129	$70	84.3 %

Managed Care

Premium and service revenues increased 43.0% in the three months ended March 31, 2015, primarily as a result of expansions or new programs in many of our states, particularly Florida, Illinois and Ohio. Earnings from operations increased $51 million, or 115.9%, between years primarily reflecting growth in the business.

Specialty Services

Premium and service revenues increased 56.0% in the three months ended March 31, 2015, resulting primarily from increased services associated with membership growth in the Managed Care segment and growth in our AcariaHealth business. Earnings from operations increased $8 million, or 30.8% in the three months ended March 31, 2015, primarily reflecting growth in the specialty services provided to our increased Managed Care membership as well as external growth in the AcariaHealth business.

LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows used in the discussion of liquidity and capital resources ($ in millions).

	Three Months Ended March 31,	
	2015	2014
Net cash provided by operating activities	$45	$252
Net cash used in investing activities	(225)	(150)
Net cash provided by financing activities	236	131
Net increase in cash and cash equivalents	$56	$233

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 $45 million in the three months ended March 31, 2015, compared to $252 million in the comparable period in 2014. The cash provided by operations in 2015 and 2014 was primarily related to net earnings and an increase in medical claims liabilities resulting from the growth in the business, partially offset by increases in premium and related receivables.

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. Cash flow from operations was reduced in the first quarter of 2015 as a result of a one time change in payment terms for one of our states.

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The reimbursement of the HIF from our state customers may be settled as a separate payment or monthly in combination with our other premium payments. The vast majority of our state customers are settling the reimbursement through a separate payment after verification of each state's portion of our HIF, resulting in an increase in Premium and Related Receivables at March 31, 2015. 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,	
	2015	2014
Increase in premium and related receivables	$(334)	$(119)
Increase (decrease) in unearned revenue	(51)	35
Net decrease in operating cash flow	$(385)	$(84)

Cash Flows Used in Investing Activities

Investing activities used cash of $225 million for the three months ended March 31, 2015, and $150 million in the comparable period in 2014. Cash flows used in investing activities in 2015 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long term investments, capital expenditures, the acquisition of LiveHealthier and proceeds from the sale of Celtic Insurance Company.

In January 2015, we sold 25% of our ownership in Celtic Insurance Company. No gain or loss was recognized on the sale of the ownership interest. Celtic Insurance Company is included in the Specialty Services segment. Under the terms of the agreement, we entered into a put agreement with the noncontrolling interest holder to purchase the noncontrolling interest at a later date.

Cash flows used in investing activities in 2014 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long term investments, the acquisition of U.S. Medical Management and capital and capital expenditures.

We spent $27 million and $18 million in the three months ended March 31, 2015 and 2014, respectively, on capital expenditures for system enhancements and market expansions.

As of March 31, 2015, our investment portfolio consisted primarily of fixed-income securities with an average duration of 3.1 years. We had unregulated cash and investments of $97 million at March 31, 2015, compared to $85 million at December 31, 2014.

Cash Flows Provided by Financing Activities

Our financing activities provided cash of $236 million in the three months ended March 31, 2015, compared to $131 million in the comparable period in 2014. In January 2015, we issued an additional $200 million of 4.75% Senior Notes at par. In connection with the January 2015 issuance, we entered into interest rate swap agreements for a notional amount of $200 million. During 2014, our financing activities primarily related to net borrowings under our revolving credit facility.

Liquidity Metrics

The $500 million revolving credit agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. We are required not to exceed a maximum debt-to-EBITDA ratio of 3.0 to 1.0. As of March 31, 2015, we had $125 million in

borrowings outstanding under our revolving credit facility and we were in compliance with all covenants. As of March 31, 2015, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

We had outstanding letters of credit of $30 million as of March 31, 2015, which were not part of our revolving credit facility. We also had letters of credit for $52 million (valued at the March 31, 2015 conversion rate), or €48 million, representing our proportional share of the letters of credit issued to support Ribera Salud's outstanding debt which are a part of the revolving credit facility. Collectively, the letters of credit bore interest at 1.73% as of March 31, 2015. In addition, we had outstanding surety bonds of $196 million as of March 31, 2015.

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The indentures governing our Senior Notes contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio.

At March 31, 2015, we had working capital, defined as current assets less current liabilities, of $247 million, compared to $134 million at December 31, 2014. 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, 2015, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 38.0%, compared to 33.5% at December 31, 2014. Excluding the $69 million non-recourse mortgage note, our debt to capital ratio was 36.6% as of March 31, 2015, compared to 31.7% at December 31, 2014. We utilize the debt to capital ratio as a measure, among others, of our leverage and financial flexibility.

2015 Expectations

As previously discussed, in January 2015, we announced a definitive agreement to acquire Agate Resources, Inc. The transaction is expected to close during the third quarter of 2015, subject to customary closing conditions and regulatory approvals.

During the remainder of 2015, we expect to make net capital contributions to our insurance subsidiaries of approximately $390 million associated with our growth and spend approximately $117 million in additional capital expenditures primarily associated with system enhancements and market expansions. These capital contributions are expected to be funded by unregulated cash flow generation in 2015 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 will be sufficient to finance our general operations and capital expenditures for at least 12 months from the date of this filing.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

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

Our subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of March 31, 2015, our subsidiaries had aggregate statutory capital and surplus of $1,624 million, compared with the required minimum aggregate statutory capital and surplus requirements of $871 million. During the three months ended March 31, 2015, we contributed $301 million of statutory capital to our subsidiaries. We estimate our Risk Based Capital, or RBC, percentage (including KSHP) to be in excess of 350% of the Authorized Control Level (excluding the interim impact of the health insurer fee).

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, 2015, 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, 2015, we had short term investments of $151 million and long term investments of $1,625 million, including restricted deposits of $98 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. Substantially all of 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, 2015, the fair value of our fixed income investments would decrease by approximately $46 million. Declines in interest rates over time will reduce our investment income.

We have interest rate swap agreements for a notional amount of $750 million 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 $750 million of our long term debt varies with market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at March 31, 2015, the fair value of our debt would decrease by approximately $36 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 Part II, Item 1A "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 overall 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 healthcare 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, an increase in the expected rate of inflation for healthcare costs or other factors may affect our ability to control the impact of healthcare cost increases.

ITEM 4. Controls and Procedures.

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

principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Form 10-Q, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of March 31, 2015. 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, 2015.

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, 2015 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.

On July 5, 2013, the Company's subsidiary, Kentucky Spirit Health Plan, Inc. (Kentucky Spirit), terminated its contract with the Commonwealth of Kentucky (the Commonwealth). Kentucky Spirit believes it had a contractual right to terminate the contract and filed a lawsuit in Franklin Circuit Court seeking a declaration of this right. The Commonwealth has alleged that Kentucky Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25 million performance bond. The Commonwealth's attorneys have asserted that the Commonwealth's expenditures due to Kentucky Spirit's departure range from $28 million to $40 million plus interest, and that the associated CMS expenditures range from $92 million to $134 million. Kentucky Spirit disputes the Commonwealth's alleged damages, and is pursuing its own litigation claims for damages against the Commonwealth.

On February 6, 2015, the Kentucky Court of Appeals affirmed a Franklin Circuit Court ruling that Kentucky Spirit does not have a contractual right to terminate the contract early. The Court of Appeals also found that the contract’s liquidated damages provision “is applicable in the event of a premature termination of the Contract term.” Kentucky Spirit intends to seek Kentucky Supreme Court review of the finding that its departure constituted a breach of contract. The Commonwealth may seek review of the ruling that the liquidated damages provision is applicable in the event of a premature termination.

Kentucky Spirit also filed a lawsuit in April 2013, amended in October 2014, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches. On December 9, 2014, the Franklin Circuit Court denied the Commonwealth's motion for partial summary judgment on Kentucky Spirit's damages claims. On March 15, 2015, the Franklin Circuit Court denied the Commonwealth's motion to stay discovery and ordered that discovery proceed on those claims.

On March 9, 2015, the Secretary of the Kentucky Cabinet for Health and Family Services (CHFS) issued a determination letter finding that Kentucky Spirit owed the Commonwealth $40 million in actual damages plus prejudgment interest at 8 percent. On March 18, 2015, in a letter to the Kentucky Finance and Administration Cabinet, Kentucky Spirit contested CHFS' jurisdiction to make such a determination. Depending on the response from the Finance and Administration Cabinet, Kentucky Spirit may bring the matter to the Franklin Circuit Court.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If Kentucky Spirit prevails on its claims, it would be entitled to damages. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. The Company is unable to estimate the ultimate outcome resulting from the Kentucky litigation. As a result, the Company has not recorded any receivable or any liability for potential damages under the contract as of March 31, 2015. While uncertain, the ultimate resolution of the pending litigation could have a material effect on the financial position, cash flow or results of operations of the Company in the period it is resolved or becomes known.

Excluding the Kentucky matters discussed above, the Company is also routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters in the normal course of business 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, results of operations or cash flows.

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.

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Reductions in funding or changes to eligibility requirements for government sponsored healthcare programs in which we participate could substantially affect our financial position, results of operations and cash flows.

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, CHIP, LTC, ABD, Foster Care and Health Insurance Marketplace premiums. The base premium rate paid for each program differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region and benefit mix. 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 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. Governments periodically consider reducing or reallocating the amount of money they spend for Medicaid, Medicare, CHIP, LTC, ABD and Foster Care. Adverse economic conditions may continue to put pressures on state budgets as tax and other state revenues decrease while the population that is eligible to participate in these programs increases, creating more need for funding. We anticipate this will require government agencies to find funding alternatives, which may result in reductions in funding for programs, contraction of covered benefits, and limited or no premium rate increases or premium rate decreases. A reduction (or less than expected increase), a protracted delay, or a change in allocation methodology in government funding for these programs, as well as termination of the contract for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows.

Additionally, changes in these programs could reduce the number of persons enrolled in or eligible for these programs or increase our administrative or healthcare costs under these programs. Recent legislation generally requires that eligibility levels be maintained, but this could cause states to reduce reimbursement or reduce benefits in order for states to afford to maintain eligibility levels. 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 results of operations, financial position and cash flows.

Lastly, if a federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicaid, Medicare, CHIP, LTC, ABD, Foster Care and the new Health Insurance Marketplaces, may be delayed. If the federal government fails to make payments under these programs on a timely basis, our business could suffer, and our financial position, results of operations or cash flows may be materially affected.

Failure to accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs could negatively affect our financial position, results of operations or cash flows.

Our profitability, to a significant degree, depends on our ability to estimate and effectively manage expenses related to health benefits through our ability to contract favorably with hospitals, physicians and other healthcare providers. For example, our Medicaid revenue is often based on bids submitted before the start of the initial contract year. If our actual medical expense exceeds our estimates, our health benefits ratio, or our expenses related to medical services as a percentage of premium revenue, would increase and our profits would decline. 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 utilization of healthcare services, hospital and pharmaceutical costs, major epidemics or pandemics, new medical technologies, pharmaceutical compounds and other external factors, including general economic conditions such as inflation and unemployment levels, are beyond our control and could reduce our ability to accurately predict and effectively control the costs of providing health benefits.

Our medical expense includes claims reported but not paid, estimates for claims incurred but not reported, 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 as well as inpatient acuity 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. However, we still cannot be sure that our medical claims liability estimate is adequate or that adjustments to the estimate will not unfavorably impact our results of operations.

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Additionally, when we commence operations in a new state, region or product, we have limited information with which to estimate our medical claims liability. For a period of time after the inception of the new business, we base our estimates on state-provided historical actuarial data and limited actual incurred and received claims and inpatient acuity information. The addition of new categories of individuals who are eligible under new legislation may pose the same difficulty in estimating our medical claims liability. Similarly, we may face difficulty in estimating our medical claims liability in 2015 for the relatively new and evolving Health Insurance Marketplaces.

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. If it is determined that our estimates are significantly different than actual results, our results of operations and financial position could be adversely affected. In addition, if there is a significant delay in our receipt of premiums, our business operations, cash flows, or earnings could be negatively impacted.

The implementation of the Health Reform Legislation and other reforms could materially and adversely affect our results of operations, financial position and cash flows.

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 generally upheld by the Supreme Court in 2012, the Court determined 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 was expanded to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to each states' election. The federal government will pay the entire costs for Medicaid coverage for newly eligible beneficiaries for three years (2014 through 2016). Beginning in 2017, the federal share begins to decline, ending at 90% for 2020 and subsequent years. As of March 6, 2015, 29 states and the District of Columbia have expanded Medicaid eligibility, and additional states continue to discuss expansion. The ACA also maintained CHIP eligibility standards through September 2019.

The ACA required the establishment of Health Insurance Marketplaces for individuals and small employers to purchase health insurance coverage commencing in January 2014. Open enrollment for coverage in 2015 began on November 15, 2014 and continued until February 15, 2015. The ACA required insurers participating on the Health Insurance Marketplaces to offer a minimum level of benefits and included guidelines on setting premium rates and coverage limitations.

Our ability to adequately price products offered in the Health Insurance Marketplaces may have a negative impact on our results of operations, financial position and cash flow. We may be adversely selected by individuals who will have a higher acuity level than the anticipated pool of participants. In addition, the risk corridor, reinsurance and risk adjustment ("three Rs") provisions of the ACA established to reduce risk for insurers may not be effective in appropriately mitigating the financial risks related to the Marketplace product. Further, the reinsurance and risk corridor components may not be adequately funded. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, the three Rs, or other assumptions utilized in setting adequate premium rates could have a material adverse effect on our results of operations, financial position and cash flows.

Our attempts to diversify our business lines through participation in Health Insurance Marketplaces established by the federal government, or “Federally-Facilitated Marketplaces,” may be impacted if the United States Supreme Court determines that the Internal Revenue Service may not extend tax-credit subsidies to health insurance coverage purchased through Federally-Facilitated Marketplaces. Individuals who would have otherwise received a tax-credit subsidy may choose not to enroll for coverage through a Federally-Facilitated Marketplace if the Supreme Court makes this determination and other changes are not made by the states to remedy this.

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 Health Insurance Marketplaces. Arkansas became the first state to obtain federal approval to use Medicaid funding to purchase private insurance for low-income residents and we began operations under the program beginning January 1, 2014.

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The ACA imposes an annual insurance industry assessment of $8.0 billion starting in 2014, and $11.3 billion in each of 2015 and 2016, with increasing annual amounts thereafter. Such assessments are not deductible for income tax purposes. The fee will be allocated based on health insurers' premium revenues in the previous year. Each health insurer's fee is calculated by multiplying its market share by the annual fee. Market share is based on commercial, Medicare, and Medicaid premium revenue. Not-for-profit insurers may have a competitive advantage since they are exempt from paying the fee if they receive at least 80% of their premium revenue from Medicare, Medicaid, and CHIP, and other not-for-profit insurers are allowed to exclude 50% of their premium revenue from the fee calculation. If this federal premium assessment is imposed as enacted, and if we are not reimbursed by the states for the cost of the federal premium assessment (including the associated tax impact), or if we are unable to otherwise adjust our business model to address this new assessment, our results of operations, financial position and cash flows may be materially adversely affected.

There are numerous 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 effect 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 healthcare reform, or do not do so as effectively as our competitors, our results of operations may be materially adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application 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. In addition, the managed care industry has received negative publicity that has led to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health and/or human services departments that oversee the activities of managed care organizations providing or arranging to provide services to Medicaid, Medicare and Health Insurance Marketplace enrollees. For example, our health plan subsidiaries, as well as our applicable specialty companies, must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements.

The frequent enactment of, changes to, or interpretations of laws and regulations 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; restrict revenue and enrollment growth; increase our healthcare and administrative costs; impose additional capital and surplus requirements; and increase or change our liability to members in the event of malpractice by our contracted providers. In addition, changes in political party or administrations at the state, federal or country level may change the attitude towards healthcare programs.

Additionally, the taxes and fees paid to federal, state and local governments may increase due to several factors, including: enactment of, changes to, or interpretations of tax laws and regulations, audits by governmental authorities, geographic expansions into higher taxing jurisdictions and the effect of expansions into international markets.

Our contracts with states may require us to maintain a minimum health benefits ratio (HBR) or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to return premium back to the state in the event profits exceed established levels or HBR does not meet the minimum requirement. Other states

may require us to meet certain performance and quality metrics in order to maintain our contract or receive additional or full contractual revenue.

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The governmental healthcare programs in which we participate are subject to the satisfaction of certain regulations and performance standards. For example, under Health Reform Legislation, Congress authorized CMS and the states to implement managed care demonstration programs to serve dually eligible beneficiaries to improve the coordination of their care. Participation in these demonstration programs is subject to CMS approval and the satisfaction of conditions to participation, including meeting certain performance requirements. Our inability to improve or maintain adequate quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs. Specifically, several of our Medicaid contracts require us to maintain a Medicare health plan. Although we strive to comply with all existing regulations and to meet performance standards applicable to our business, failure to meet these requirements could result in financial fines and penalties. Also, states may not allow us to continue to participate in their government programs, or we may fail to win procurements to participate in such programs which could materially and adversely affect our results of operations, financial position and cash flows.

In addition, as a result of the expansion of our businesses and operations conducted in foreign countries, we face political, economic, legal, compliance, regulatory, operational and other risks and exposures that are unique and vary by jurisdiction. These foreign regulatory requirements with respect to, among other items, environmental, tax, licensing, intellectual property, privacy, data protection, investment, capital, management control, labor relations, and fraud and corruption regulations are different than those faced by our domestic businesses. In addition, we are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act. Our failure to comply with laws and regulations governing our conduct outside the United States or to successfully navigate international regulatory regimes that apply to us could adversely affect our ability to market our products and services, which may have a material adverse effect on our business, financial condition and results of operations.

Our businesses providing pharmacy benefit management (PBM) and specialty pharmacy services face regulatory and other risks and uncertainties which could materially and adversely affect our results of operations, financial position and cash flows.

We provide PBM and specialty pharmacy services through our US Script and AcariaHealth businesses. Each business is subject to federal and state laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. They also conduct business as a mail order pharmacy and specialty pharmacy, which subjects them to extensive federal, state and local laws and regulations. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including the receipt or disclosure of rebates from pharmaceutical companies, the development and use of formularies, and the use of average wholesale prices.

Our PBM and specialty pharmacy businesses would be materially and adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers and other suppliers, and could face potential claims in connection with purported errors by our mail order or specialty pharmacies, including in connection with the risks inherent in the authorization, compounding, packaging and distribution of pharmaceuticals and other healthcare products. Disruptions at any of our mail order or specialty pharmacies due to an event that is beyond our control could affect our ability to process and dispense prescriptions in a timely manner and could materially and adversely affect our results of operations, financial position and cash flows.

If any of our government contracts are terminated or are not renewed or we receive an adverse review, audit or investigation, our business will suffer.

We provide managed care programs and selected services to individuals receiving benefits under governmental assistance programs. We provide those healthcare services under contracts with regulatory entities in the areas in

which we operate. Our government contracts are generally intended to run for three years and may be extended for additional years if the contracting entity or its agent elects to do so. When our contracts expire, they may be opened for bidding by competing healthcare providers, and there is no guarantee that our contracts will be renewed or extended. Competitors may buy their way into the market by submitting bids with lower pricing. Further, our government contracts contain certain provisions regarding eligibility, enrollment and dis-enrollment processes for covered services, eligible providers, periodic financial and informational reporting, quality assurance, timeliness of claims payment and agreement to maintain a Medicare plan in the state and financial standards and are subject to cancellation if we fail to perform in accordance with the standards set by regulatory agencies.

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We are also subject to various reviews, audits and investigations to verify our compliance with the terms of our contracts with various governmental agencies 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 programs; increased difficulty in selling our products and services; or loss of one or more of our licenses.

If any of our government contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, or we have an adverse review, audit or investigation, our business will suffer, our goodwill could be impaired and our financial position, results of operations or cash flows may be materially affected.

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

Our health plans rely on other state-operated systems or subcontractors to qualify, solicit, educate and assign eligible members into managed care plans. The effectiveness of these state operations and subcontractors 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 subcontractors, there is an increased potential for an unanticipated impact on the overall number of members assigned to managed care plans.

Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity.

We maintain a significant investment portfolio of cash equivalents and short term and long term investments in a variety of securities, which are subject to general credit, liquidity, market and interest rate risks 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.

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

Our growth strategy includes the acquisition of health plans participating in government sponsored healthcare programs and specialty services businesses, contract rights and related assets of other health plans both in our existing service areas and in new markets and start-up operations in new markets or new products in existing markets. Although we review the records of companies or businesses we plan to acquire, it is possible that we could assume unanticipated liabilities or adverse operating conditions, or an acquisition may not perform as well as expected or may not achieve timely profitability. We also face the risk that we will not be able to effectively integrate acquisitions into our existing operations effectively without substantial expense, delay or other operational or financial problems and we may need to divert more management resources to integration than we planned.

In connection with start-up operations, we may incur significant expenses prior to commencement of operations and the receipt of revenue. 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 administer a state contract and process claims. We may experience delays in operational start dates. As a result of these factors, start-up operations may decrease our profitability. In addition, we are planning to expand our business internationally and we will be 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.

If we are unable to effectively execute our growth strategy, our future growth will suffer and our results of operations could be harmed.

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 government sponsored health plan business in order to grow our revenue stream and balance our dependence on 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 government sponsored programs. Our ineffectiveness in marketing specialty services to third-parties may impair our ability to execute our business strategy.

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Adverse credit market conditions may have a material adverse effect 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 at times been restricted. In the event we need access to additional capital to pay our operating expenses, fund subsidiary surplus requirements, make payments on or refinance 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.

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. As part of normal operations, we may make requests for 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, the funds available to us would be limited, which could harm our ability to implement our business strategy.

We derive a majority of our premium revenues from operations in a limited 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 limited number of 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 process. Our inability to continue to operate in any of the states in which we operate could 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 networks, 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 healthcare reform legislation and potential growth in our segment may attract new competitors.

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 complementary industries, 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, as a

result of industry consolidation or otherwise, 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.

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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 at competitive prices 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 on a timely basis or under favorable terms enabling us to service our members profitably. Healthcare providers with whom we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

In any particular market, physicians and other healthcare providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical costs or difficulty in meeting regulatory or accreditation requirements. In some markets, certain healthcare providers, particularly hospitals, physician/hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part. In addition, accountable care organizations, practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other healthcare providers choose may change the way in which these providers interact with us and may change the competitive landscape. Such organizations or groups of healthcare providers may compete directly with us, which could adversely affect our operations, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. Provider networks may consolidate, resulting in a reduction in the competitive environment. In addition, if these providers refuse to contract with us, use their market position to negotiate contracts unfavorable to us or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

From time to time healthcare providers assert or threaten to assert claims seeking to terminate non-cancelable agreements due to alleged actions or inactions by us. In addition, we are aware that other managed care organizations have been subject to class action lawsuits by healthcare providers with respect to claim payment procedures, and we may be subject to similar lawsuits. Regardless of whether any lawsuits 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. If we are unable to retain our current provider contract terms or enter into new provider contracts timely or on favorable terms, our profitability may be harmed.

We may be unable to attract, retain or effectively manage the succession of key personnel.

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our business. We would be adversely impacted if we are unable to adequately plan for the succession of our executives and senior management. While we have succession plans in place for members of our executive and senior management team, these plans do not guarantee that the services of our executive and senior management team will continue to be available to us. Our ability to replace any departed members of our executive and 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 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. If we are unable to attract, retain and effectively manage the succession plans for key personnel, executives and senior management, our business and financial position, results of operations or cash flows could be harmed.

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 healthcare 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. 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, 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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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, including, without limitation, medical malpractice claims. 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, and could therefore 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.

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.

If we fail to comply with applicable privacy, security, and data laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

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 the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act and the Gramm-Leach-Bliley Act, which require us to protect the privacy of medical records and safeguard personal health information we maintain and use. Certain of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities. Despite our best attempts to maintain adherence to information privacy and security best practices as well as compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to privacy or security breaches, acts of vandalism or theft, malware, misplaced or lost data including paper or electronic media, programming and/or human errors or other similar events. In the past, we have had data breaches resulting in disclosure of confidential or protected health information that have not resulted in any material financial loss or penalty to date. However, future data breaches could require us to expend significant resources to remediate any damage, interrupt our operations and damage our reputation, subject us to state or federal agency review and could also result in enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, reputation and results of operations, financial position and cash flows.

In addition, 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 for 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. In addition, HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities with a focus on security risk assessments. Although we are not aware of HHS plans to audit any of our covered entities, an audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

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Under HIPAA, health plans are required to have the capacity to accept and send all covered transactions in a standardized electronic format. Penalties can be imposed for failure to comply with these requirements. The transaction standards have been modified to version 5010 to prepare for the implementation of the ICD-10 coding system. While we have prepared for the transition to ICD-10 in October 2015, if unforeseen circumstances arise, it is possible that we could be exposed to investigations and allegations of noncompliance. In addition, if some providers continue to use ICD-9 codes on claims after October 1, 2015, we may have to reject such claims, which may lead to claim resubmissions, increased call volume and provider and customer dissatisfaction. Further, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, which could result in higher costs and reimbursement levels, or lost revenues under risk adjustment. During the transition to ICD-10, certain claims processing and payment information we have historically used to establish our reserves may not be reliable or available in a timely manner. As a result, implementation of ICD 10 may have a material adverse effect on our results of operations, financial position and cash flows.

A failure in or breach of our operational or security systems or infrastructure, or those of third parties with which we do business, including as a result of cyber attacks, could have an adverse effect on our business.

Information security risks have significantly increased in recent years in part because of the proliferation of new technologies, the use of the internet and telecommunications technologies to conduct our operations, and the increased sophistication and activities of organized crime, hackers, terrorists and other external parties, including foreign state agents. Our operations rely on the secure processing, transmission and storage of confidential, proprietary and other information in our computer systems and networks.

Security breaches may arise from external or internal threats. External breaches include hacking personal information for financial gain, attempting to cause harm to our operations, or intending to obtain competitive information. We experience attempted external hacking or malicious attacks on a regular basis. We maintain a rigorous system of preventive and detective controls through our security programs; however, our prevention and detection controls may not prevent or identify all such attacks. Internal breaches may result from inappropriate security access to confidential information by rogue employees, consultants or third party service providers. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, financial data, competitively sensitive information, or other proprietary data, whether by us or a third party, could have a material adverse effect on our business reputation, financial condition, cash flows, or results of operations.

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

On January 2, 2015, the Company completed the acquisition of LiveHealthier, Inc. whereby the initial transaction consideration was partially financed through an issuance of $13 million (247,580 shares) of Centene common stock. The Company issued shares in reliance upon the exemption contained in Section 4(a)(2) of the Securities Act of 1933, as amended, as a transaction not involving a public offering.

Issuer Purchases of Equity Securities
First Quarter 2015

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, 2015	8,314	$52.99	—	3,335,448
February 1 - February 28, 2015	67,047	54.83	—	3,335,448
March 1 - March 31, 2015	6,818	64.11	—	3,335,448
Total	82,179	$55.41	—	3,335,448

(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 3,335,448 shares. No duration has been placed on the repurchase program.

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ITEM 6. Exhibits.

EXHIBIT NUMBER	DESCRIPTION
10.1*	Form of Amendment of Executive Severance and Change in Control Agreement.
12.1	Computation of ratio of earnings to fixed charges.
31.1	Certification of Chairman, President and Chief Executive Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Executive Vice President and Chief Financial Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chairman, President and Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Executive Vice President and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.1	XBRL Taxonomy Instance Document.
101.2	XBRL Taxonomy Extension Schema Document.
101.3	XBRL Taxonomy Extension Calculation Linkbase Document.
101.4	XBRL Taxonomy Extension Definition Linkbase Document.
101.5	XBRL Taxonomy Extension Label Linkbase Document.
101.6	XBRL Taxonomy Extension Presentation Linkbase Document.

* Indicates a management contract or compensatory plan or arrangement.

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized as of April 28, 2015.

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)