CENTENE CORP
Form 10-Q
October 27, 2009

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

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

For the quarterly period ended September 30, 2009

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	42-1406317
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)
7711 Carondelet Avenue St. Louis, Missouri	63105
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code:

(314) 725-4477

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

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of “large accelerated filer”, “accelerated filer” and “small reporting company” in Rule 12b-2 of the Exchange Act. Large accelerated filer T Accelerated filer £ Non-accelerated filer £ (do not check if a smaller reporting company) Smaller reporting company £

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

As of October 16, 2009, the registrant had 45,403,369 shares of common stock outstanding.

CENTENE CORPORATION

QUARTERLY REPORT ON FORM 10-Q

TABLE OF CONTENTS

Table of Contents

PART I

FINANCIAL INFORMATION

ITEM 1. Financial Statements.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS
(In thousands, except share data)
(Unaudited)

	September 30, 2009	December 31, 2008
ASSETS		
Current assets:		
Cash and cash equivalents of continuing operations	$389,135	$370,999
Cash and cash equivalents of discontinued operations	4,847	8,100
Total cash and cash equivalents	393,982	379,099
Premium and related receivables, net of allowance for uncollectible accounts of $19 and $595, respectively	104,798	92,531
Short-term investments, at fair value (amortized cost $45,332 and $108,469, respectively)	45,692	109,393
Other current assets	61,294	75,333
Current assets of discontinued operations other than cash	8,292	9,987
Total current assets	614,058	666,343
Long-term investments, at fair value (amortized cost $475,078 and $329,330, respectively)	486,889	332,411
Restricted deposits, at fair value (amortized cost $17,177 and $9,124, respectively)	17,286	9,254
Property, software and equipment, net of accumulated depreciation of $96,314 and $74,194, respectively	209,920	175,858
Goodwill	219,100	163,380
Intangible assets, net	23,454	17,575
Other long-term assets	37,100	59,083
Long-term assets of discontinued operations	27,207	27,248
Total assets	$1,635,014	$1,451,152
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$410,997	$373,037
Accounts payable and accrued expenses	204,411	219,566
Unearned revenue	68,024	17,107
Current portion of long-term debt	645	255
Current liabilities of discontinued operations	23,846	31,013
Total current liabilities	707,923	640,978
Long-term debt	276,687	264,637
Other long-term liabilities	55,992	43,539
Long-term liabilities of discontinued operations	1,155	726
Total liabilities	1,041,757	949,880

Commitments and contingencies		
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; issued and outstanding 45,402,369 and 45,071,179 shares, respectively	45	45
Additional paid-in capital	277,709	263,835
Accumulated other comprehensive income:		
Unrealized gain on investments, net of tax	7,812	3,152
Retained earnings	335,192	275,236
Treasury stock, at cost (2,373,893 and 2,083,415 shares, respectively)	(46,497)	(40,996)
Total Centene stockholders' equity	574,261	501,272
Noncontrolling interest	18,996	—
Total stockholders' equity	593,257	501,272
Total liabilities and stockholders' equity	$1,635,014	$1,451,152

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

Table of Contents

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS
(In thousands, except share data)
(Unaudited)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2009	2008	2009	2008
Revenues:				
Premium	$ 960,009	$ 817,740	$ 2,754,713	$ 2,338,550
Service	27,300	17,962	72,740	56,958
Premium and service revenues	987,309	835,702	2,827,453	2,395,508
Premium tax	50,925	22,897	182,685	66,249
Total revenues	1,038,234	858,599	3,010,138	2,461,757
Expenses:				
Medical costs	803,062	671,920	2,298,108	1,932,172
Cost of services	15,843	12,854	46,364	43,467
General and administrative expenses	130,024	118,628	381,524	323,391
Premium tax	51,295	23,284	183,785	66,636
Total operating expenses	1,000,224	826,686	2,909,781	2,365,666
Earnings from operations	38,010	31,913	100,357	96,091
Other income (expense):				
Investment and other income	3,750	2,708	11,781	15,724
Interest expense	(4,064)	(4,377)	(12,210)	(12,436)
Earnings from continuing operations, before income tax expense	37,696	30,244	99,928	99,379
Income tax expense	12,426	12,145	35,060	38,464
Earnings from continuing operations, net of income tax expense	25,270	18,099	64,868	60,915
Discontinued operations, net of income tax (benefit) expense of $(792), $242, $(1,148) and $390, respectively	(1,460)	149	(2,394)	1,159
Net earnings	23,810	18,248	62,474	62,074
Noncontrolling interest	2,542		2,518	
Net earnings attributable to Centene Corporation	$ 21,268	$ 18,248	$ 59,956	$ 62,074
Amounts attributable to Centene Corporation common shareholders:				
Earnings from continuing operations, net of income tax expense	$ 22,728	$ 18,099	$ 62,350	$ 60,915
Discontinued operations, net of income tax (benefit) expense	(1,460)	149	(2,394)	1,159
Net earnings	$ 21,268	$ 18,248	$ 59,956	$ 62,074
Net earnings (loss) per share attributable to Centene Corporation:				
Basic:				
Continuing operations	$ 0.53	$ 0.42	$ 1.45	$ 1.40

Discontinued operations	(0.04)		(0.06)	0.03
Earnings per common share	$ 0.49	$ 0.42	$ 1.39	$ 1.43
Diluted:				
Continuing operations	$ 0.51	$ 0.41	$ 1.41	$ 1.37
Discontinued operations	(0.03)		(0.05)	0.02
Earnings per common share	$ 0.48	$ 0.41	$ 1.36	$ 1.39
Weighted average number of shares outstanding:				
Basic	43,001,870	43,232,941	43,023,431	43,381,819
Diluted	44,291,604	44,530,347	44,247,153	44,541,424

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

Table of Contents

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENT OF STOCKHOLDERS' EQUITY
(In thousands, except share data)
(Unaudited)
Nine Months Ended September 30, 2009

	Centene Stockholders' Equity								
	Common Stock				Treasury Stock				
	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Income	Retained Earnings	$.001 Par Value Shares	Amt	Non controlling Interest	Total
Balance, December 31, 2008	45,071,179	$ 45	$ 263,835	$ 3,152	$ 275,236	2,083,415	$ (40,996)	$ —	$ 501,272
Consolidation of Access Health Solutions LLC	—	—	—	—	—	—	—	29,144	29,144
Consolidation of Centene Center LLC	—	—	—	—	—	—	—	17,400	17,400
Comprehensive Earnings:									
Net earnings	—	—	—	—	59,956	—	—	2,518	62,474
Change in unrealized investment gains, net of $2,846 tax	—	—	—	4,660	—	—	—	—	4,660
Total comprehensive earnings									67,134
Common stock issued for employee benefit plans	331,190	—	2,403	—	—		—	—	2,403
Common stock repurchases	—	—	—	—	—	292,478	(5,539)	—	(5,539)
Treasury stock issued for compensation	—		—	—	—	(2,000)	38		38
Stock compensation expense	—	—	11,428	—	—	—	—	—	11,428
Excess tax benefits from stock compensation	—	—	43	—	—	—	—	—	43

Conversion fee1	—	—	—	—	—	—	—	(26,895)	(26,895)
Distributions to noncontrolling interest	—	—	—	—	—	—	—	(3,171)	(3,171)
Balance, September 30, 2009	45,402,369	$ 45	$ 277,709	$ 7,812	$ 335,192	2,373,893	$ (46,497)	$ 18,996	$ 593,257

(1) Conversion fee represents additional purchase price to noncontrolling holders of Access Health Solutions LLC for the transfer of membership to the Company's wholly-owned subsidiary, Sunshine State Health Plan, Inc.

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

Table of Contents

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)
(Unaudited)

	Nine Months Ended September 30,	
	2009	2008
Cash flows from operating activities:		
Net earnings	$62,474	$62,074
Adjustments to reconcile net earnings to net cash provided by operating activities		
Depreciation and amortization	30,800	26,018
Stock compensation expense	11,428	11,576
Loss on sale of investments, net	261	4,923
Deferred income taxes	4,516	13,987
Changes in assets and liabilities —		
Premium and related receivables	(381)	(50,797)
Other current assets	(2,595)	(6,422)
Other assets	(593)	(713)
Medical claims liabilities	31,612	28,109
Unearned revenue	54,725	(37,931)
Accounts payable and accrued expenses	(17,656)	74,723
Other operating activities	2,386	967
Net cash provided by operating activities	176,977	126,514
Cash flows from investing activities:		
Capital expenditures	(42,696)	(52,588)
Purchases of investments	(647,086)	(372,221)
Sales and maturities of investments	546,640	356,367
Investments in acquisitions, net of cash acquired, and investment in equity method investee	(31,533)	(83,509)
Net cash used in investing activities	(174,675)	(151,951)
Cash flows from financing activities:		
Proceeds from exercise of stock options	1,717	4,770
Proceeds from borrowings	468,500	152,005
Payment of long-term debt	(456,059)	(109,410)
Distributions to noncontrolling interest	(3,171)	
Contribution from noncontrolling interest	7,495	
Excess tax benefits from stock compensation	43	3,016
Common stock repurchases	(5,539)	(18,244)
Debt issue costs	(405)	
Net cash provided by financing activities	12,581	32,137
Net increase in cash and cash equivalents	14,883	6,700
Cash and cash equivalents, beginning of period	379,099	268,584
Cash and cash equivalents, end of period	$393,982	$275,284
Supplemental disclosures of cash flow information:		
Interest paid	$8,556	$8,467

Income taxes paid	$43,308	$28,370
Supplemental disclosure of non-cash investing and financing activities:		
Contribution from noncontrolling interest	$5,491	$

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

Table of Contents

CENTENE CORPORATION AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Dollars in thousands, except share data)
(Unaudited)

1. Organization and Operations

Centene Corporation, or the Company, is a multi-line healthcare enterprise operating in two segments: Medicaid Managed Care and Specialty Services. The Medicaid Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program, or CHIP, Foster Care, Medicare Special Needs Plans and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled program, or ABD. The Specialty Services segment provides related services, including behavioral health, life and health management, long-term care programs, managed vision, telehealth services, and pharmacy benefits management, to state programs, healthcare organizations, employer groups, and other commercial organizations, as well as to the Company's own subsidiaries. The Specialty Services segment also provides a full range of healthcare solutions for individuals and the rising number of uninsured Americans.

2. Basis of Presentation

The unaudited interim financial statements herein have been prepared pursuant to the rules and regulations of the Securities and Exchange Commission. 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 for the fiscal year ended December 31, 2008. Accordingly, footnote disclosures, which would substantially duplicate the disclosures contained in the December 31, 2008 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.

Beginning January 1, 2009, the Company has presented the investment in Access Health Solutions LLC, or Access, as a consolidated subsidiary in its financial statements. Prior to January 1, 2009, Access had been recorded under the equity method of accounting. We determined that we should have accounted for our investment in Access as a consolidated subsidiary since July 1, 2007. The impact of the difference in presentation is not material to our financial statements for any period. As a result of the presentation of Access as a consolidated subsidiary beginning January 1, 2009, cash flows from investing activities increased by $4,839 to reflect the cash held by Access on January 1, 2009. The noncontrolling interest of Access is presented within stockholders' equity.

Certain 2008 amounts in the consolidated financial statements have been reclassified to conform to the 2009 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported. Any material subsequent events have been considered for disclosure through the filing date of this Form 10-Q.

3. Recent Accounting Pronouncements

Effective January 1, 2009, the Company adopted new guidance related to business combinations. The changes from the previous guidance include, but are not limited to: (1) acquisition costs are recognized separately from the acquisition; (2) known contractual contingencies at the time of the acquisition are considered part of the liabilities acquired and and measured at their fair value; all other contingencies are part of the liabilities acquired and measured at their fair value only if it is more likely than not that they meet the definition of a liability; (3) contingent consideration based on the outcome of future events is recognized and measured at the time of the acquisition; and

(4) business combinations achieved in stages (step acquisitions) recognize the identifiable assets and liabilities, as well as noncontrolling interest, in the acquiree, at the full amounts of their fair values. The new guidance will be utilized for all acquisitions after January 1, 2009.

Effective January 1, 2009, the Company adopted new guidance related to consolidation and reporting of noncontrolling interest, which was issued to improve the relevance, comparability, and transparency of financial information provided to investors by requiring all entities to report noncontrolling (minority) interests in subsidiaries in the same way, that is, as equity in the consolidated financial statements. Moreover, this guidance eliminates the diversity that existed in accounting by requiring transactions between an entity and noncontrolling interest be treated as equity transactions. As discussed in Note 2, Basis of Presentation, and Note 7, Centene Center LLC, the noncontrolling interest in Access and Centene Center LLC is presented within stockholders' equity.

In April 2009, new guidance was issued related to the recognition and presentation of other-than-temporary impairments. The guidance applies to fixed maturity securities only and requires separate display of losses related to credit deterioration and losses related to other market factors. When an entity does not intend to sell the security and it is more likely than not that an entity will not have to sell the security before recovery of its cost basis, it must recognize the credit component of an other-than-temporary impairment in earnings and the remaining portion in other comprehensive income. The adoption of the guidance did not have a material effect on the Company's financial statements.

In June 2009, new guidance was issued related the consolidation of variable interest entities to require an analysis to determine whether a variable interest gives the entity a controlling financial interest in a variable interest entity. This guidance requires an ongoing reassessment and eliminates the quantitative approach previously required for determining whether an entity is the primary beneficiary. This guidance is effective for fiscal years beginning after November 15, 2009 and early adoption is prohibited. The Company is currently evaluating the impact of adopting this guidance on the consolidated financial statements and related disclosures.

The Company has determined that all other recently issued accounting guidance will not have a material impact on its consolidated financial position, results of operations and cash flows, or do not apply to its operations.

4. Discontinued Operations: University Health Plans, Inc.

In November 2008, the Company announced its intention to sell certain assets of its New Jersey health plan, University Health Plans, Inc., or UHP. The assets, liabilities and results of operations of UHP were classified as discontinued operations for all periods presented beginning in December 2008. UHP was previously reported in the Medicaid Managed Care segment. The total revenue associated with UHP included in results from discontinued operations was $37,170 and $38,538 for the three months ended September 30, 2009 and 2008, respectively, and $109,256 and $112,086 for the nine months ended September 30, 2009 and 2008, respectively. Additional information regarding the sale of UHP is included in Note 13, Contingencies.

In 2008, the Company conducted an impairment analysis of the assets of UHP. The impairment analysis resulted in an impairment charge associated with property, software and equipment of $2,546. During the nine months ending September 30, 2009, the Company incurred additional exit costs primarily related to employee retention programs. In total, the Company has incurred $3,403 of exit costs. The change in the exit cost liability for UHP is summarized as follows:

Balance, December 31, 2008	$1,110
Incurred	2,293
Paid	(1,104)

Balance, September 30, 2009	$2,299

5. Acquisitions

2009 Acquisitions

- Access. In July 2007, the Company acquired a 49% ownership interest in Access, a Medicaid managed care entity in Florida. The Company accounted for its investment in Access using the equity method of accounting through December 31, 2008. During the quarter ended March 31, 2009, the Company began presenting its investment in Access as a consolidated subsidiary in its financial statements. The consolidation of Access resulted in goodwill of approximately $44,500, and other identified intangible assets of approximately $5,400. In 2009, the Company paid an additional $26,895 conversion fee for the transfer of membership from Access to the Company's wholly-owned subsidiary, Sunshine State Health Plan, Inc.

- Additional 2009 Acquisitions. The Company acquired assets of the following entities: Pediatric Associates LLC, effective February 2009, Amerigroup Community Care of South Carolina, Inc., effective March 2009 and InSpeech, Inc., effective July 2009. The Company paid a total of approximately $12,500 in cash for these acquisitions. Goodwill of approximately $9,500 and other identifiable intangible assets of approximately $1,500 were included in the Medicaid Managed Care segment and other identifiable intangible assets of $1,700 were included in the Specialty Services segment, all of which is deductible for income tax purposes.

Table of Contents

2008 Acquisition

- Celtic Insurance Company. On July 1, 2008, the Company acquired Celtic Insurance Company, or Celtic. The Company paid approximately $82,100 in cash and related transaction costs, net of unregulated cash acquired. In conjunction with the closing of the acquisition, Celtic paid to the Company an extraordinary dividend of $31,411 in July 2008. Goodwill of $24,300 and other identifiable intangible assets of $8,600 were included in the Specialty Services segment.

6. Goodwill

The following table summarizes the changes in goodwill by operating segment:

	Medicaid Managed Care	Specialty Services	Total
Balance as of December 31, 2008	$ 51,548	$ 111,832	$ 163,380
Acquisitions	54,028	1,692	55,720
Balance as of September 30, 2009	$ 105,576	$ 113,524	$ 219,100

Increases to goodwill in 2009 were related to the presentation of Access as a consolidated subsidiary and the acquisitions discussed in Note 5, Acquisitions.

7. Centene Center LLC

In June 2009, the Company executed an agreement as a 50% joint venture partner in a real estate development entity, Centene Center LLC, to include the Company's corporate headquarters. Centene Center LLC is a variable interest entity, or VIE, and the Company concluded it was the primary beneficiary. Accordingly, the Company's consolidated financial statements include the accounts of Centene Center LLC. The Company's interest in Centene Center LLC includes an initial equity investment of $17,400. Centene Center LLC has posted a $1,750 letter of credit to a tenant of the development, collateralized by a portion of the entity's cash balances. The assets and liabilities of Centene Center LLC as of September 30, 2009 are as follows (on a 100% basis):

Total Assets	$71,242
Total Liabilities	$36,438
Equity Centene Corporation (50% ownership)	$17,402
	17,402

Joint venture partners (50% ownership)	
Total equity	$34,804
Total Liabilities and Equity	$71,242

As part of financing the real estate development, the joint venture executed a $95,000 construction loan due June 1, 2011, which may be extended for two additional one year terms. The Company and its development partner have guaranteed up to $65,000 each associated with this construction loan. As of September 30, 2009, there were no amounts outstanding under this loan. Additional information regarding the construction loan is included in Note 10, Debt.

8. Investments and Restricted Deposits

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

	September 30, 2009				December 31, 2008			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
U.S. Treasury securities	$26,579	$ 282	$ (1)	$26,860	$4,054	$ 130	$ —	$4,184
Corporate securities	82,040	655	(184)	82,511	47,733	74	(1,154)	46,653
State and municipal securities	380,846	11,338	(57)	392,127	360,638	5,964	(11)	366,591
Equity securities	9,734	381	(198)	9,917	7,183	17	(885)	6,315
Money market funds	4,018	—	—	4,018	12,988	—	—	12,988
Life insurance contracts	14,573	—	—	14,573	14,327	—	—	14,327
Asset backed securities	19,797	64	—	19,861	—	—	—	—
Total	$537,587	$ 12,720	$ (440)	$549,867	$446,923	$ 6,185	$ (2,050)	$451,058

The Company's investments are classified as available for sale with the exception of life insurance contracts and certain cost method investments. The Company 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. Based on management's intent and ability to not sell these investments prior to their anticipated recovery, no other than temporary impairment has been recorded in the nine months ended September 30, 2009. Investments in a gross unrealized loss position at September 30, 2009 and December 31, 2008, are as follows:

	September 30, 2009				December 31, 2008			
	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	$(1)	$1,134	$—	$—	$—	$314	$—	$—

Corporate securities	(183)	39,825	(1)	86	(1,071)	20,898	(83)	2,072
State and municipal securities	(56)	8,790	(1)	101	(9)	3,798	(2)	101
Equity securities	(98)	730	(100)	602	(885)	2,658	—	—
Asset backed securities	—	—	—	—	—	—	—	—
Total	$(338)	$50,479	$(102)	$789	$(1,965)	$27,668	$(85)	$2,173

Table of Contents

The contractual maturities of short-term and long-term investments and restricted deposits as of September 30, 2009, are as follows:

	Investments		Restricted Deposits	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value
One year or less	$45,332	$45,692	$10,188	$10,193
One year through five years	387,473	399,063	6,989	7,093
Five years through ten years	31,628	31,879	—	—
Greater than ten years	55,977	55,947	—	—
Total	$520,410	$532,581	$17,177	$17,286

The contractual maturities of short-term and long-term investments and restricted deposits as of December 31, 2008, are as follows:

	Investments		Restricted Deposits	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value
One year or less	$108,469	$109,393	$6,038	$6,044
One year through five years	181,958	185,867	3,086	3,210
Five years through ten years	56,936	56,188	—	—
Greater than ten years	90,436	90,356	—	—
Total	$437,799	$441,804	$9,124	$9,254

Actual maturities may differ from contractual maturities due to call or prepayment options. Asset backed securities are included in the one year through five years category, while equity securities and life insurance contracts are included in the five years through ten years category.

The Company’s gross recorded realized gains and losses on investments were as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2009	2008	2009	2008
Gains	$ 297	$ 300	$ 850	$ 872
Losses	(128)	(4,726)	(1,111)	(5,097)

9. Fair Value Measurements

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

Level Input:	Input Definition:
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.

Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

The following table summarizes fair value measurements by level at September 30, 2009 for assets and liabilities measured at fair value on a recurring basis:

	Level I	Level II	Level III	Total
Cash and cash equivalents	$389,135			$389,135
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$17,311	$1,735	$	$19,046
Corporate securities		72,838		72,838
State and municipal securities		392,127		392,127
Equity securities	3,790			3,790
Asset backed securities		19,861		19,861
Total investments	$21,101	$486,561	$	$507,662
Restricted deposits available for sale:				
Cash and cash equivalents	$4,249	$	$	$4,249
Certificates of deposit	5,223			5,223
U.S. Treasury securities and obligations of U.S. government corporations and agencies	7,814			7,814
Total restricted deposits	$17,286	$	$	$17,286
Total assets at fair value	$427,522	$486,561	$	$914,083

In prior periods, the fair value estimates of corporate securities and state and municipal securities were categorized as Level I. The fair value of a cost method investment is not estimated if there are no identified events or changes in circumstances that may have a significant adverse effect on the fair value of the investment. The aggregate carrying amount of the Company's life insurance contracts and cost-method investments was $24,919 as of September 30, 2009.

10. Debt

Debt consists of the following:

	September 30, 2009	December 31, 2008
$175,000 senior notes	$ 175,000	$ 175,000
$300,000 revolving credit agreement	86,000	63,000
Mortgage note payable	10,000	
$20,500 revolving loan agreement		20,364
Capital leases	6,332	6,528

Joint venture construction loan		
Total debt	277,332	264,892
Less current maturities	(645)	(255)
Long-term debt	$ 276,687	$ 264,637

Table of Contents

$20,500 Revolving Loan Agreement and Mortgage Note Payable

During the third quarter of 2009, the Company paid the balance of the revolving loan agreement and refinanced a portion of the balance with another bank as a mortgage note payable. The note is collateralized by the Company's existing headquarters building and parking garage. The mortgage is due August 31, 2014 and bears interest at the LIBOR rate plus 3%. The mortgage includes financial covenants requiring a minimum fixed charge coverage ratio.

Joint Venture Construction Loan

In June 2009, the Company and its development partner executed a $95,000 construction loan associated with the construction of a real estate development to include the Company's corporate headquarters. The construction loan is due June 1, 2011 which may be extended for two additional one year terms. The loan bears interest at the LIBOR rate plus 4% with a minimum rate of 5%. The Company and its development partner have each guaranteed up to $65,000 associated with the construction loan. The agreement contains non-financial and financial covenants, including requirements for the Company to maintain a specified net worth. As of September 30, 2009, there were no amounts outstanding under the construction loan.

11. Earnings Per Share

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2009	2008	2009	2008
Earnings (loss) attributable to Centene Corporation common shareholders:				
Earnings from continuing operations, net of tax	$ 22,728	$ 18,099	$ 62,350	$ 60,915
Discontinued operations, net of tax	(1,460)	149	(2,394)	1,159
Net earnings	$ 21,268	$ 18,248	$ 59,956	$ 62,074
Shares used in computing per share amounts:				
Weighted average number of common shares outstanding	43,001,870	43,232,941	43,023,431	43,381,819
Common stock equivalents (as determined by applying the treasury stock method)	1,289,734	1,297,406	1,223,722	1,159,605
Weighted average number of common shares and potential dilutive common shares outstanding	44,291,604	44,530,347	44,247,153	44,541,424
Net earnings (loss) per share attributable to Centene Corporation:				
Basic:				
Continuing operations	$ 0.53	$ 0.42	$ 1.45	$ 1.40
Discontinued operations	(0.04)	—	(0.06)	0.03
Earnings per common share	$ 0.49	$ 0.42	$ 1.39	$ 1.43
Diluted:				
Continuing operations	$ 0.51	$ 0.41	$ 1.41	$ 1.37

Discontinued operations		(0.03)		—		(0.05)		0.02
Earnings per common share	$	0.48	$	0.41	$	1.36	$	1.39

The calculation of diluted earnings per common share for the three and nine months ended September 30, 2009 excludes the impact of 2,352,841 and 2,546,193 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units. The calculation of diluted earnings per common share for the three and nine months ended September 30, 2008 excludes the impact of 1,784,542 and 1,438,852 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

12. Stockholders' Equity

On October 26, 2009, the Company's Board of Directors extended the Company's stock repurchase program. The program authorizes the repurchase of up to 4,000,000 shares of the Company's common stock from time to time on the open market or through privately negotiated transactions. No duration has been placed on the repurchase program and the Company reserves the right to discontinue the repurchase program at any time. During the nine months ended September 30, 2009, the Company repurchased 292,478 shares at an average price of $18.94 and an aggregate cost of $5,539.

13. Contingencies

On January 8, 2009, the Company filed a complaint in the Chancery Division of the Superior Court of New Jersey, asserting a breach of contract claim against Amerigroup New Jersey, or AGPNJ, and a tortious interference with contract claim against Amerigroup Corporation, in connection with AGPNJ's refusal to proceed to closing under its contract to purchase certain assets of UHP's business. In December 2008, AGPNJ sent the Company a termination notice claiming that a material adverse effect had occurred under the contract and attempted to terminate the contract. The Company contested whether a material adverse effect had occurred and correspondingly the propriety and validity of the purported termination, and sought to obtain specific performance of the contract and damages. On April 20, 2009, Amerigroup Corporation and AGPNJ answered the complaint and filed a counterclaim alleging that there had been misrepresentations and/or omissions of material fact made by or on behalf of UHP and the Company.

On October 23, 2009, the parties entered into a settlement agreement resolving the legal claims discussed above. Pursuant to the settlement agreement, AGPNJ will move forward with the transaction to purchase the assets, which is subject to regulatory approval and expected to be completed during the first quarter of 2010.

In May 2008, the Internal Revenue Services began an audit of the Company's 2006 and 2007 tax returns. As a result of this audit, the IRS has initially denied the $34,856 tax benefit the Company recognized for the abandonment of the FirstGuard stock in 2007. The Company is proceeding with the appeals process and believes that it is more likely than not that the Company's tax position will be upheld. Accordingly, the Company has not made any adjustments to the reserve for this position.

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

Table of Contents

14. Segment Information

Centene operates in two segments: Medicaid Managed Care and Specialty Services. The Medicaid Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene's specialty companies including behavioral health, individual health, life and health management, long-term care, managed vision, telehealth services and pharmacy benefits management functions.

Segment information for the three months ended September 30, 2009, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 917,135	$121,099	$ —	$ 1,038,234
Revenue from internal customers	17,182	143,725	(160,907)	—
Total revenue	$ 934,317	$264,824	$ (160,907)	$ 1,038,234
Earnings from operations	$ 32,245	$5,765	$ —	$ 38,010

Segment information for the three months ended September 30, 2008, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 766,523	$92,076	$ —	$ 858,599
Revenue from internal customers	15,337	118,029	(133,366)	—
Total revenue	$ 781,860	$210,105	$ (133,366)	$ 858,599
Earnings from operations	$ 27,015	$4,898	$ —	$ 31,913

Segment information for the nine months ended September 30, 2009, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 2,658,911	$351,227	$ —	$ 3,010,138
Revenue from internal customers	49,306	409,897	(459,203)	—
Total revenue	$ 2,708,217	$761,124	$ (459,203)	$ 3,010,138
Earnings from operations	$ 70,335	$30,022	$ —	$ 100,357

Segment information for the nine months ended September 30, 2008, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 2,228,209	$233,548	$ —	$ 2,461,757
Revenue from internal customers	45,041	346,707	(391,748)	—
Total revenue	$ 2,273,250	$580,255	$ (391,748)	$ 2,461,757
Earnings from operations	$ 81,219	$14,872	$ —	$ 96,091

15. Comprehensive Earnings

Differences between net earnings and total comprehensive earnings resulted from changes in unrealized gains (losses) on investments available for sale, as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2009	2008	2009	2008
Net earnings	$ 23,810	$ 18,248	$ 62,474	$ 62,074
Reclassification adjustment, net of tax	93	131	(48)	188
Change in unrealized gains (losses) on investments, net of tax	2,638	(1,504)	4,708	(1,410)
Total change	2,731	(1,373)	4,660	(1,222)
Comprehensive earnings	26,541	16,875	67,134	60,852
Comprehensive earnings attributable to the noncontrolling interest	2,542	—	2,518	—
Comprehensive earnings attributable to Centene Corporation	$ 23,999	$ 16,875	$ 64,616	$ 60,852

Table of Contents

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, and in our annual report on Form 10-K for the year ended December 31, 2008.

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 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 I, 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. Actual results may differ from projections or estimates due to a variety of important factors, including:

- our ability to accurately predict and effectively manage health benefits and other operating expenses;
- competition;
- changes in healthcare practices;
- changes in federal or state laws or regulations;
- inflation;
- provider contract changes;
- new technologies;
- reduction in provider payments by governmental payors;
- major epidemics;
- disasters and numerous other factors affecting the delivery and cost of healthcare;
- the expiration, cancellation or suspension of our Medicaid managed care contracts by state governments;
- availability of debt and equity financing, on terms that are favorable to us; and
- general economic and market conditions.

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.

Table of Contents

OVERVIEW

We are a multi-line healthcare enterprise operating in two segments. The Medicaid Managed Care segment provides Medicaid and Medicaid-related programs to organizations and individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program, or CHIP, and, Supplemental Security Income including Aged, Blind or Disabled programs, or ABD. The Specialty Services segment provides specialty services, including behavioral health, life and health management, long-term care programs, managed vision, telehealth services and pharmacy benefits management, to state programs, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries. Our Specialty Services segment also provides a full range of healthcare solutions for individuals and the rising number of uninsured Americans.

During 2008, we announced our intention to sell certain assets of University Health Plans, Inc., or UHP, our New Jersey health plan. Unless specifically noted, with the exception of cash flow information, the discussions below are in the context of continuing operations, and therefore, exclude UHP. The results of operations for UHP are classified as discontinued operations for all periods presented.

The first quarter of 2008 included $20.8 million of premium revenue for the Georgia premium rate increase for July 1, 2007 through December 31, 2007. All 2008 ratios and year over year changes discussed below are inclusive of this revenue.

Our third quarter performance for 2009 is summarized as follows:

- Quarter-end at-risk managed care membership of 1,386,400.
- Total revenues of $1,038.2 million.
- Health Benefits Ratio, or HBR, of 83.7%.
- General and Administrative, or G&A, expense ratio of 13.2%.
- Operating earnings of $38.0 million.
- Diluted earnings per share of $0.51.
- Operating cash flows of $114.9 million.

The following new contracts and acquisition contributed to our growth over the last year:

- In July 2009, we began operating under our contract in Massachusetts to manage health care services for the Central, Northern, Boston and Southern regions operating as CeltiCare Health Plan of Massachusetts. At September 30, 2009, we served 500 members.
- In March 2009, we completed an acquisition of certain assets in South Carolina. We now serve 46,100 at-risk members in South Carolina at September 30, 2009.
- In February 2009, we began converting non-risk managed care membership in Florida from Access Health Solutions LLC, or Access, to our new subsidiary, Sunshine State Health Plan on an at-risk basis. At September 30, 2009, we served 84,400 members on an at-risk basis while Access served 59,200 members on a non-risk basis. Beginning January 1, 2009, we have presented our investment in Access as a consolidated subsidiary.
- In October 2008, we began operating under our contract in Arizona to provide Acute Care services in Yavapai county, with 17,400 members at September 30, 2009.

Table of Contents

RESULTS OF OPERATIONS AND KEY METRICS

Summarized comparative financial data are as follows ($ in millions, except share data):

	Three Months Ended September 30,			Nine Months Ended September 30,		
	2009	2008	% Change 2008-2009	2009	2008	% Change 2008-2009
Premium	$960.0	$817.7	17.4 %	$2,754.7	$2,338.6	17.8 %
Service	27.3	18.0	52.0 %	72.7	57.0	27.7 %
Premium and service revenues	987.3	835.7	18.1 %	2,827.4	2,395.6	18.0 %
Premium tax	50.9	22.9	122.4 %	182.7	66.2	175.8 %
Total revenues	1,038.2	858.6	20.9 %	3,010.1	2,461.8	22.3 %
Medical costs	803.1	671.9	19.5 %	2,298.1	1,932.2	18.9 %
Cost of services	15.8	12.9	23.3 %	46.3	43.5	6.7 %
General and administrative expenses	130.0	118.6	9.6 %	381.5	323.4	18.0 %
Premium tax expense	51.3	23.3	120.3 %	183.8	66.6	175.8 %
Earnings from operations	38.0	31.9	19.1 %	100.4	96.1	4.4 %
Investment and other income, net	(0.3)	(1.7)	(81.2)%	(0.4)	3.3	(113.0)%
Earnings from continuing operations, before income tax expense	37.7	30.2	24.6 %	100.0	99.4	0.6 %
Income tax expense	12.4	12.1	2.3 %	35.1	38.5	(8.8)%
Earnings from continuing operations, net of income tax expense	25.3	18.1	39.6 %	64.9	60.9	6.5 %
Discontinued operations, net of income tax (benefit) expense of $(0.8), $0.2, $(1.1) and $0.4 respectively	(1.5)	0.1	%	(2.4)	1.2	%
Net earnings	23.8	18.2	30.5 %	62.5	62.1	0.6 %
Noncontrolling interest	2.5		%	2.5		%
Net earnings attributable to Centene Corporation	$21.3	$18.2	16.5 %	$60.0	$62.1	(3.4)%
Diluted earnings per common share attributable to Centene Corporation:						
Continuing operations	$0.51	$0.41	24.4 %	$1.41	$1.40	0.7 %
Discontinued operations	(0.03)		%	(0.05)	0.03	(266.7)%
Total diluted earnings per common share	$0.48	$0.41	17.1 %	$1.36	$1.43	(4.9)%

Revenues and Revenue Recognition

Our Medicaid Managed Care segment generates revenues primarily from premiums we receive from the states in which we operate health plans. We receive a fixed premium per member per month pursuant to our state contracts. We generally receive premium payments during the month we provide services and recognize premium revenue during the period in which we are obligated to provide services to our members. In some instances, our base

premiums are subject to an adjustment, or risk score, based on the acuity of our membership. Generally, the risk score is determined by the state analyzing encounter submissions of processed claims data to determine the acuity of our membership relative to the entire state's Medicaid membership.

Some states enact premium taxes or similar assessments, collectively, premium taxes, and these taxes are recorded as a component of revenues as well as operating expenses. During the second quarter of 2009, one of the states in which we operate increased their premium which was required to be passed through to hospitals in the state. During the three and nine months ended September 30, 2009, the $24.3 million and $109.0 million respective increases were recorded as premium tax revenue and expense.

Some contracts allow for additional premium associated with certain supplemental services provided, such as maternity deliveries. Revenues are recorded based on membership and eligibility data provided by the states, which may be adjusted by the states for updates to this data. These eligibility adjustments have been immaterial in relation to total revenue recorded and are reflected in the period known.

Our Specialty Services segment generates revenues under contracts with state programs, healthcare organizations, and other commercial organizations, as well as from our own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of services.

Premium and service revenues collected in advance are recorded as unearned revenue. For performance-based contracts, we do not recognize revenue subject to refund until data is sufficient to measure performance. Premium and service revenues due to us are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and our management's judgment on the collectability of these accounts. As we generally receive payments during the month in which services are provided, the allowance is typically not significant in comparison to total revenues and does not have a material impact on the presentation of our financial condition or results of operations.

Our total revenue increased in the three and nine months ended September 30, 2009 over the previous year primarily through 1) membership growth, 2) premium rate increases, and 3) growth in Specialty Services.

1. Membership growth

From September 30, 2008 to September 30, 2009, we increased our at-risk managed care membership by 18.4%. The following table sets forth our membership by state for our managed care organizations:

	September 30,	
	2009	2008
Arizona	17,400	—
Florida	84,400	—
Georgia	303,400	283,900
Indiana	200,700	172,400
Massachusetts	500	—
Ohio	151,200	132,500
South Carolina	46,100	26,600
Texas	450,200	433,200
Wisconsin	132,500	122,500
Total at-risk membership	1,386,400	1,171,100
Non-risk membership	63,200	3,700

Total	1,449,600	1,174,800

Table of Contents

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

	September 30,	
	2009	2008
Medicaid	1,040,500	850,500
CHIP & Foster Care	263,400	261,800
ABD & Medicare	82,500	58,800
Total at-risk membership	1,386,400	1,171,100
Non-risk membership	63,200	3,700
Total	1,449,600	1,174,800

The following table provides supplemental information of other membership categories:

	September 30,	
	2009	2008
Cenpatico Behavioral Health:		
Arizona	117,300	102,400
Kansas	41,000	40,100
Bridgeway:		
Long-term Care	2,500	1,900

From September 30, 2008 to September 30, 2009, our membership increased as a result of growth in all of our states. We have experienced strong organic membership growth in Georgia, Indiana, Ohio, Texas and Wisconsin. In South Carolina, our membership increased as a result of an acquisition and the conversion of the state's fee-for-service members into managed care. In February 2009, we began converting Access members in Florida to at-risk under our Sunshine State Health Plan. At September 30, 2009, we had 84,400 at-risk members, while Access continued to serve 59,200 members on a non-risk basis. In Arizona, we began providing Acute Care services in Yavapai county during October 2008.

2. Premium rate increases

During the nine months ended September 30, 2009, we received premium rate increases in certain markets which yield a 2.1% composite increase across all of our markets. During the nine months ended September 30, 2008, we received premium rate increases in certain markets which yield a 2.9% composite increase across all of our markets.

In November 2007, we received a contract amendment from the State of Georgia providing for an effective premium rate increase in Georgia of approximately 3.8% effective July 1, 2007. The state also mandated service changes, retroactively recalculated certain rate cells and adjusted for duplicate member issues. We executed this amendment on November 16, 2007. The State of Georgia returned the fully executed contract in January 2008 and, accordingly, we recorded the additional revenue, retroactive to July 1, 2007, in the first quarter of 2008. The premium revenue, related to the period from July 1, 2007 to December 31, 2007, totals approximately $20.8 million. Approximately $7.3 million of this amount is related to the mandated services, rate cell changes and duplicate member issues, the

remaining $13.5 million yields a calculated 3.8% increase.

The 2008 rate increase for the state of Georgia effective July 1, 2008 was not fully executed until the fourth quarter of 2008 and accordingly, the premium revenue from July 1, 2008 to September 30, 2008 was recorded in the fourth quarter of 2008. Consistent with 2008, we expect to record the premium revenue from July 1, 2009 to September 30, 2009 in the fourth quarter of 2009.

3. Specialty Services growth

For the three and nine months ended September 30, 2009, Specialty Services from external customers was $121.1 million and $351.2 million, compared to $92.1 million and $233.5 million for the same prior year periods. The increase is primarily attributable to the commencement of our acute care business under Bridgeway, the acquisition of Celtic as well as increased membership in our behavioral health company, Cenpatico.

Medical Costs

Our medical costs include payments to physicians, hospitals, and other providers for healthcare and specialty services claims. Medical costs also include estimates of medical expenses incurred but not yet reported, or IBNR, and estimates of the cost to process unpaid claims. We use our judgment to determine the assumptions to be used in the calculation of the required IBNR estimate. The assumptions we consider include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims.

Our development of the IBNR estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified.

Additionally, we consult with independent actuaries to review our estimates on a quarterly basis. The independent actuaries provide us with a review letter that includes the results of their analysis of our medical claims liability. We do not solely rely on their report to adjust our claims liability. We utilize their calculation of our claims liability only as additional information, together with management's judgment to determine the assumptions to be used in the calculation of our liability for medical costs.

While we believe our IBNR estimate is appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. Accordingly, we can not assure you that healthcare claim costs will not materially differ from our estimates.

Our results of operations depend on our ability to manage expenses associated with health benefits and to accurately predict costs incurred. Our health benefits ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding premium taxes) and reflects the direct relationship between the premium received and the medical services provided. The table below depicts our HBR for our external membership by member category:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2009	2008	2009	2008
Medicaid and CHIP	84.7%	81.3%	84.4%	80.7%

ABD and Medicare	81.1	88.1	81.7	91.4
Specialty Services	80.5	79.9	79.6	82.9
Total	83.7	82.2	83.4	82.6

Our consolidated HBR for the three and nine months ended September 30, 2009 was 83.7% and 83.4%, respectively. The change for the three and nine month periods as compared to 2008 are increase of 1.5% and 0.8%, respectively. The increase in the three months ended September 30, 2009 over the comparable period in 2008 was due to the March 1, 2009 rate decrease for our CHIP/Perinate product in Texas which brought the HBR more in line with our normal range and the impact of additional costs related to the flu. We also experienced improvements in our ABD product, particularly in Ohio, which was mostly offset by the impact of changes in rates and benefit structures in other markets.

Table of Contents

The increase for the nine months ended September 30, 2009 as compared to 2008 is due to the effect of recording the Georgia premium rate increase retroactive to July 1, 2007 during the first quarter of 2008. The retroactive Georgia premium rate increase in the first quarter of 2008 had the effect of decreasing the HBR for the nine month period by 0.8%. Adjusting for the impact due to the Georgia rate increase, our HBR was flat. Sequentially our consolidated HBR increased from 83.1% in the second quarter to 83.7%. The higher HBR reflects the impact of additional costs related to the flu along with the effect of reserving at higher rates for new markets and receiving pass-through payments which increase the HBR ratio.

Cost of Services

Our cost of services expense includes the pharmaceutical costs associated with our pharmacy benefit manager's external revenues. Cost of services also includes costs associated with providing service to our non-risk members as well as all direct costs to support the functions responsible for generation of our services revenues. These expenses consist of the salaries and wages of the professionals and teachers who provide the services and expenses associated with facilities and equipment used to provide services.

General and Administrative Expenses

Our general and administrative expenses, or G&A, primarily reflect wages and benefits, including stock compensation expense, and other administrative costs associated with our health plans, specialty companies and centralized functions that support all of our business units. Our major centralized functions are finance, information systems and claims processing.

Our G&A expense ratio represents G&A expenses as a percentage of Premium and Service revenues, and reflects the relationship between revenues earned and the costs necessary to earn those revenues. The consolidated G&A expense ratio for the three and nine months ended September 30, 2009 were 13.2% and 13.5%, respectively, compared to 14.2% and 13.5% for the same prior year periods. The nine months ended September 30, 2008 ratio reflects a 0.1% decrease due to the effect of recording the Georgia premium rate increase retroactive to July 1, 2007 during the first quarter of 2008. The decreasing G&A expense ratios reflect improved leveraging of our costs over a higher revenue base and the impact of additional revenue from new business (Arizona Acute Care, Florida and South Carolina).
Other Income (Expense)

The following table summarizes the components of other income (expense), net (in millions):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2009	2008	2009	2008
Investment income	$ 3.8	$ 5.7	$ 11.8	$ 15.6
Reserve Primary fund loss	—	(4.5)	—	(4.5)
Earnings from equity method investee	—	1.5	—	4.6
Interest expense	(4.1)	(4.4)	(12.2)	(12.4)
Other income (expense), net	$ (0.3)	$ (1.7)	$ (0.4)	$ 3.3

Investment income decreased $1.9 million and $3.8 million in the three and nine months ended September 30, 2009, over the comparable period in 2008. The decrease over the comparable 2008 periods is due to the decline in market interest rates. Additionally, during the three months ended September 30, 2008, we recorded a loss of $4.5 million on the Reserve Primary money market fund. Earnings from equity method investee decreased due to the presentation of our investment in Access as a consolidated subsidiary beginning in 2009.

Income Tax Expense

Our effective tax rate for the three and nine months ended September 30, 2009 was 33.0% and 35.1%, respectively, compared to 40.2% and 38.7% in the comparable periods in 2008. The decrease was primarily due to lower state taxes and the effect of the presentation of the noncontrolling interest in consolidated subsidiaries. Excluding the effect of the noncontrolling interest, our effective tax rate would be 35.3% and 36.0% for the three and nine months ended September 30, 2009, respectively.

Discontinued Operations

In November 2008, we announced our intention to sell certain assets of UHP, our New Jersey health plan. Accordingly, the results of operations for UHP are reported as discontinued operations for all periods presented. UHP was previously reported in the Medicaid Managed Care segment. In November 2008, we announced a definitive agreement to sell certain assets of our New Jersey health plan to Amerigroup New Jersey, or AGPNJ. In December 2008, AGPNJ sent us a termination notice. We have filed a complaint seeking specific performance of the contract and damages. In October 2009, we entered into a settlement agreement with AGPNJ resolving all claims. Pursuant to the settlement agreement, AGPNJ will proceed to close on the purchase of assets. Additional information regarding this matter is included in “Item 1. Legal Proceedings” included elsewhere in this Quarterly Report on Form 10-Q.

The pre-tax loss from discontinued operations was $2.3 million for the three months ended September 30, 2009 compared to pre-tax earnings of $0.4 million in the same period of 2008. Legal expenses of $1.1 million and employee retention expenses of $0.8 million related to the pending sale of UHP were included in the results from discontinued operations during the third quarter of 2009. The pre-tax loss from discontinued operations was $3.5 million for the nine months ended September 30, 2009 compared to pre-tax earnings of $1.5 million in the same period of 2008. The assets and liabilities of the discontinued business are segregated in the consolidated balance sheet.

Table of Contents

LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows for the nine months ended September 30, 2009 and 2008, that we use throughout the discussion of liquidity and capital resources (in millions).

	Nine Months Ended September 30,	
	2009	2008
Net cash provided by operating activities	$ 177.0	$ 126.5
Net cash used in investing activities	(174.7)	(151.9)
Net cash provided by financing activities	12.6	32.1
Net increase in cash and cash equivalents	$ 14.9	$ 6.7

We finance our activities primarily through operating cash flows and borrowings under our revolving credit facility. Our total operating activities provided cash of $177.0 million in the nine months ended September 30, 2009 compared to $126.5 million in the comparable period in 2008. The net cash provided by operating activities in 2009 reflect the collection of Ohio's October capitation payment of $51.9 million in September 2009. Net cash provided by operating activities in 2008 reflects an increase in receivables at September 30, 2008 as both Wisconsin and Indiana withheld September premium payments until October 2008.

Our investing activities used cash of $174.7 million in the nine months ended September 30, 2009 compared to $151.9 million in the comparable period in 2008. Net cash used in investing activities fluctuates from year to year due to the timing of investment purchases, sales and maturities. Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets within our investment guidelines. As of September 30, 2009, our investment portfolio consisted primarily of fixed-income securities with an average duration of 2.7 years. Cash is invested in investment vehicles such as municipal bonds, corporate bonds, instruments of the U.S. Treasury, insurance contracts, commercial paper, bank deposits, asset backed securities and equity securities. These securities generally are actively traded in secondary markets and the reported fair market value is determined based on recent trading activity and other observable inputs. Our investment guidelines are compliant with the regulatory restrictions enacted in each state.

We spent $42.7 million and $52.6 million in the nine months ended September 30, 2009 and 2008, respectively, on capital assets consisting primarily of building construction, software and hardware upgrades, furniture, equipment, and leasehold improvements associated with office and market expansions. Exclusive of our real estate development discussed below, we anticipate spending an additional $9 million on capital expenditures in 2009 primarily associated with system enhancements and market expansions.

In 2009, our capital expenditures included $22.1 million for costs associated with the construction of a real estate development on the property adjoining our corporate office, which we believe is necessary to accommodate our growing business. The expenditures in 2008 included the cost of property purchased contiguous to our corporate headquarters. We anticipate spending an additional $31 million on capital expenditures related to the real estate construction in 2009. During the second quarter of 2009, we executed an arrangement as a joint venture partner in an entity that will develop the properties.

In June 2009, this joint venture executed a $95 million construction loan associated with the construction of a real estate development to include our corporate headquarters. The construction loan is due June 1, 2011 and may be extended for two additional one year terms. The loan bears interest at the LIBOR rate plus 4% with a minimum rate of 5%. We and our development partner have each guaranteed up to $65 million associated with the construction loan. The agreement contains non-financial and financial covenants, including requirements for us to maintain a specified net worth. As of September 30, 2009, there were no amounts outstanding under the construction loan. Additionally, the joint venture has posted a $1.75 million letter of credit to a tenant of the development, collateralized by a portion of the entity's cash balances.

Our financing activities provided cash of $12.6 million and $32.1 million in the nine months ended September 30, 2009 and 2008, respectively. During 2009 and 2008, our financing activities primarily related to proceeds from borrowings under our $300 million credit facility and stock repurchases.

At September 30, 2009, we had working capital, defined as current assets less current liabilities, of $(93.9) million, as compared to $25.4 million at December 31, 2008. Our working capital was negative at September 30, 2009 due to our efforts to increase investment returns through purchases of investments that have maturities greater than one year and, therefore, were classified as long-term. 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.

Cash, cash equivalents and short-term investments were $434.8 million at September 30, 2009 and $480.4 million at December 31, 2008. Long-term investments were $504.2 million at September 30, 2009 and $341.7 million at December 31, 2008, including restricted deposits of $17.3 million and $9.3 million, respectively. At September 30, 2009, cash and investments held by our unregulated entities totaled $27.6 million while cash and investments held by our regulated entities totaled $911.4 million. Additionally, we held regulated cash and investments of $26.8 million from discontinued operations. Upon completion of the sale of assets of UHP and the subsequent payment of medical claims liabilities and other liabilities at the closing date, substantially all of the remaining regulated cash of UHP will be transferred to our unregulated cash.

In September 2008, we recorded a realized loss of $4.5 million on our investment in the Reserve Primary money market fund. As of September 30, 2009, the carrying amount of our investment in the Reserve Primary money market fund was $4.0 million. Based on recent estimates of future distributions, we may receive up to $3.2 million additional above our carrying amount upon liquidation of the fund.

We have a $300 million Revolving Credit Agreement. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. There is a commitment fee on the unused portion of the agreement that ranges from 0.15% to 0.275% depending on the total debt to EBITDA ratio. The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt to EBITDA ratios and minimum net worth. The agreement will expire in September 2011. As of September 30, 2009, we had $86.0 million in borrowings outstanding under the agreement and $34.0 million in letters of credit outstanding, leaving availability of $180.0 million. As of September 30, 2009, we were in compliance with all covenants.

In 2007, we issued $175 million aggregate principal amount of our 7 ¼% Senior Notes due April 1, 2014, or the Notes. The Notes were registered under the Securities Act of 1933, pursuant to a registration rights agreement with the initial purchasers. The indenture governing the Notes contains non-financial and financial covenants, including requiring a minimum fixed charge coverage ratio. Interest is paid semi-annually in April and October. As of September 30, 2009, we were in compliance with all covenants.

In the third quarter of 2009, the Company paid off the balance of the revolving loan agreement and refinanced a portion of the balance with another bank as a mortgage note payable. The note is collateralized by the Company's existing headquarters building and parking garage. The mortgage bears interest at the LIBOR rate plus 3%. The mortgage includes financial covenants requiring a minimum fixed charge coverage ratio. As of September 30, 2009, we were in compliance with all covenants.

We have a stock repurchase program authorizing us to repurchase up to four million shares of common stock from time to time on the open market or through privately negotiated transactions. In October 2009, the repurchase program was extended and no duration has been placed on the repurchase program. We reserve the right to suspend or discontinue the program at any time. During the nine months ended September 30, 2009, we repurchased 292,478 shares at an average price of $18.94.

There were no other material changes outside the ordinary course of business in lease obligations or other contractual obligations in the nine months ended September 30, 2009. 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 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.

As of September 30, 2009, our subsidiaries, including UHP, had aggregate statutory capital and surplus of $451.6 million, compared with the required minimum aggregate statutory capital and surplus requirements of $283.0 million and we estimate our Risk Based Capital, or RBC, percentage to be 363% of the Authorized Control Level.

The National Association of Insurance Commissioners has adopted rules which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of September 30, 2009, each of our health plans were in compliance with the risk-based capital requirements enacted in those states.

Table of Contents

RECENT ACCOUNTING PRONOUNCEMENTS

Effective January 1, 2009, we adopted new guidance related to business combinations. The changes from the previous guidance include, but are not limited to: (1) acquisition costs are recognized separately from the acquisition; (2) known contractual contingencies at the time of the acquisition are considered part of the liabilities acquired and and measured at their fair value; all other contingencies are part of the liabilities acquired and measured at their fair value only if it is more likely than not that they meet the definition of a liability; (3) contingent consideration based on the outcome of future events is recognized and measured at the time of the acquisition; and (4) business combinations achieved in stages (step acquisitions) recognize the identifiable assets and liabilities, as well as noncontrolling interest, in the acquiree, at the full amounts of their fair values. The new guidance will be utilized for all acquisitions after January 1, 2009.

Effective January 1, 2009, we adopted new guidance related to consolidation and reporting of noncontrolling interest, which was issued to improve the relevance, comparability, and transparency of financial information provided to investors by requiring all entities to report noncontrolling (minority) interests in subsidiaries in the same way, that is, as equity in the consolidated financial statements. Moreover, the guidance eliminates the diversity that existed in accounting by requiring transactions between an entity and noncontrolling interest be treated as equity transactions. As discussed in Part I, Item 1. Financial Statements, Note 2, Basis of Presentation, the noncontrolling interest in Access is presented within stockholders' equity.

In April 2009, new guidance was issued related to the recognition and presentation of other-than-temporary impairments. The guidance applies to fixed maturity securities only and requires separate display of losses related to credit deterioration and losses related to other market factors. When an entity does not intend to sell the security and it is more likely than not that an entity will not have to sell the security before recovery of its cost basis, it must recognize the credit component of an other-than-temporary impairment in earnings and the remaining portion in other comprehensive income. The adoption of the guidance did not have a material effect on our financial statements.

In June 2009, new guidance was issued related to the consolidation of variable interest entities to require an analysis to determine whether a variable interest gives the entity a controlling financial interest in a variable interest entity. This guidance requires an ongoing reassessment and eliminates the quantitative approach previously required for determining whether an entity is the primary beneficiary. This guidance is effective for fiscal years beginning after November 15, 2009 and early adoption is prohibited. We are currently evaluating the impact of adopting this guidance on the consolidated financial statements and related disclosures.

Table of Contents

ITEM 3. Quantitative and Qualitative Disclosures About Market Risk.

INVESTMENTS

As of September 30, 2009, we had short-term investments of $45.7 million and long-term investments of $504.2 million, including restricted deposits of $17.3 million. The short-term investments generally consist of highly liquid securities with maturities between three and 12 months. The long-term investments consist of municipal, corporate and U.S. Agency bonds, life insurance contracts, U.S. Treasury investments, asset backed securities and equity securities and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long-term regardless of the contractual maturity date. Our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at September 30, 2009, the fair value of our fixed income investments would decrease by approximately $11.9 million. Declines in interest rates over time will reduce our investment income. For a discussion of the interest rate risk that our investments are subject to, see "Risk Factors–Risks Related to Our Business." Our investment portfolio may suffer losses from reductions in market interest rates and changes in market conditions which could materially and adversely affect our results of operations or liquidity.

INFLATION

While the inflation rate in 2008 for medical care costs was slightly less than that for all items, historically inflation for medical care costs has generally exceeded that 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.

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

ITEM 4. Controls and Procedures.

Evaluation of Disclosure Controls and Procedures - Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, evaluated the effectiveness of our disclosure controls and procedures as of September 30, 2009. The term "disclosure controls and procedures," as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act, means controls and other procedures of a company that are designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the company's management, including its principal executive and principal financial officers, as appropriate to allow timely decisions regarding required disclosure. Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving their objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Based on the evaluation of our disclosure controls and procedures as of September 30, 2009, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective at the reasonable assurance level.

Changes in Internal Control Over Financial Reporting - No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the quarter ended September 30, 2009 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Table of Contents

PART II

OTHER INFORMATION

ITEM 1. Legal Proceedings.

On January 8, 2009, the Company filed a complaint in the Chancery Division of the Superior Court of New Jersey, asserting a breach of contract claim against Amerigroup New Jersey, or AGPNJ, and a tortious interference with contract claim against Amerigroup Corporation, in connection with AGPNJ's refusal to proceed to closing under its contract to purchase certain assets of UHP's business. In December 2008, AGPNJ sent the Company a termination notice claiming that a material adverse effect had occurred under the contract and attempted to terminate the contract. The Company contested whether a material adverse effect had occurred and correspondingly the propriety and validity of the purported termination, and sought to obtain specific performance of the contract and damages. On April 20, 2009, Amerigroup Corporation and AGPNJ answered the complaint and filed a counterclaim alleging that there had been misrepresentations and/or omissions of material fact made by or on behalf of UHP and the Company.

On October 23, 2009, the parties entered into a settlement agreement resolving the legal claims discussed above. Pursuant to the settlement agreement, AGPNJ will move forward with the transaction to purchase the assets, which is subject to regulatory approval and expected to be completed during the first quarter of 2010.

In May 2008, the Internal Revenue Services, or IRS, began an audit of our 2006 and 2007 tax returns. As a result of this audit, the IRS has initially denied the $34.9 million tax benefit we recognized for the abandonment of the FirstGuard stock in 2007. We are proceeding with the appeals process and believe that it is more likely than not that our tax position will be upheld. Accordingly, we have not made any adjustments to our reserve for uncertain tax positions related to this issue.

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

ITEM 1A. Risk Factors.

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

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

Risks Related to Being a Regulated Entity

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

Most of our revenues come from Medicaid, CHIP and ABD premiums. The base premium rate paid by each state differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age,

gender, county or region, benefit mix and member eligibility categories. Future levels of Medicaid, CHIP and ABD funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Additionally, state and federal entities may make changes to the design of their Medicaid programs resulting in the cancellation or modification of these programs.

For example, in August 2007, the Centers for Medicare & Medicaid Services, or CMS, published a final rule regarding the estimation and recovery of improper payments made under Medicaid and CHIP. This rule requires a CMS contractor to sample selected states each year to estimate improper payments in Medicaid and CHIP and create national and state specific error rates. States must provide information to measure improper payments in Medicaid and CHIP for managed care and fee-for-service. Each state will be selected for review once every three years for each program. States are required to repay CMS the federal share of any overpayments identified. CMS published a proposed rule on July 15, 2009 that would make certain changes to the previously published rule. Among other things, the proposed changes establish a process for appealing error determinations. The changes will not become effective until the final rule is published. We cannot predict whether a final rule will become effective and if it does, what impact it will have on the states with which we have contracts.

The American Reinvestment and Recovery Act of 2009, which was signed into law on February 17, 2009, provides $87 billion in additional federal Medicaid funding for states' Medicaid expenditures between October 1, 2008 and December 31, 2010. Under this Act, states meeting certain eligibility requirements will temporarily receive additional money in the form of an increase in the federal medical assistance percentage (FMAP). Thus, for a limited period of time, the share of Medicaid costs that are paid for by the federal government will go up, and each state's share will go down. We cannot predict whether states are, or will remain, eligible to receive the additional federal Medicaid funding, or whether the states will have sufficient funds for their Medicaid programs.

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

Changes to Medicaid, CHIP, Foster Care and ABD programs could reduce the number of persons enrolled in or eligible for these programs, reduce the amount of reimbursement or payment levels, or increase our administrative or healthcare costs under these programs, all of which could have a negative impact on our business. We believe that reductions in Medicaid, CHIP, Foster Care and ABD payments could substantially reduce our profitability. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds.

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

Federal support for CHIP has been authorized through 2013. We cannot be certain that CHIP will be reauthorized when current funding expires in 2013, and if it is, what changes might be made to the program following reauthorization. Thus, we cannot predict the impact that reauthorization will have on our business.

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

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

We provide managed care programs and selected services to individuals receiving benefits under federal assistance programs, including Medicaid, CHIP and ABD. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. Our contracts with various states are generally intended to run for one or two years and may be extended for one or two additional years if the state or its agent elects to do so. Our current contracts are set to expire or renew between December 31, 2009 and September 30, 2011. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. For example, on August 25, 2006, we received notification from the Kansas Health Policy Authority that FirstGuard Health Plan Kansas, Inc.'s contract with the State would not be renewed or extended, and as a result, our contract ended on December 31, 2006. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds. For example, the Indiana contract under which we operate can be terminated by the State without cause. Our contracts could also be terminated if we fail to perform in accordance with the standards set by state regulatory agencies. If any of our contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, our business will suffer, and our financial position, results of operations or cash flows may be materially affected.

Table of Contents

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

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

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

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

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

For example, Congress is currently considering health care reform legislation. We cannot predict the impact of any such legislation, if adopted, on our business.

The pending health care reform legislation could harm our business.

Congress is currently considering legislation that could significantly reform the U.S. health care system. We cannot predict whether any legislation will be passed and if it is, what impact it will have on our business. If any reforms are implemented that reduce Medicaid or CHIP spending or the payments we receive from states, our business could suffer.

Regulations may decrease the profitability of our health plans.

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

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

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

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

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

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

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA created civil penalties for, among other things, billing for medically unnecessary goods or services. HIPAA established new enforcement mechanisms to combat fraud and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of most individually identifiable health information. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules.

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

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

In addition, the Sarbanes-Oxley Act of 2002, as well as rules subsequently implemented by the SEC and the New York Stock Exchange, or the NYSE, have imposed various requirements on public companies, including requiring changes in corporate governance practices. Our management and other personnel will continue to devote time to these

compliance initiatives.

The Sarbanes-Oxley Act requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal control over financial reporting to allow management to report on the effectiveness of our internal control over our financial reporting as required by Section 404 of the Sarbanes-Oxley Act. Our testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal control over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 causes us to incur substantial expense and management effort. Moreover, if we are not able to comply with the requirements of Section 404, or if we or our independent registered public accounting firm identifies deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the NYSE, SEC or other regulatory authorities, which would require additional financial and management resources.

Table of Contents

Changes in healthcare law and benefits may reduce our profitability.

Numerous proposals relating to changes in healthcare law have been introduced, some of which have been passed by Congress and the states in which we operate or may operate in the future. Changes in applicable laws and regulations are continually being considered, and interpretations of existing laws and rules may also change from time to time. We are unable to predict what regulatory changes may occur or what effect any particular change may have on our business. For example, these changes could reduce the number of persons enrolled or eligible to enroll in Medicaid, reduce the reimbursement or payment levels for medical services or reduce benefits included in Medicaid coverage. For example, some states have or will remove, and others are considering removing, pharmacy coverage from the services covered by managed care entities. We are also unable to predict whether new laws or proposals will favor or hinder the growth of managed healthcare in general. Legislation or regulations that require us to change our current manner of operation, benefits provided or our contract arrangements may seriously harm our operations and financial results.

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

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

Changes in federal funding mechanisms may reduce our profitability.

Changes in funding for Medicaid may affect our business. For example, on May 29, 2007, CMS issued a final rule that would reduce states' use of intergovernmental transfers for the states' share of Medicaid program funding. By restricting the use of intergovernmental transfers, this rule may restrict some states' funding for Medicaid, which could adversely affect our growth, operations and financial performance. On May 23, 2008, the United States District Court for the District of Columbia vacated the final rule as improperly promulgated. The American Recovery and Reinvestment Tax Act of 2009 indicates Congressional intent is that final regulations should not be promulgated. We cannot predict whether the rule will ever be finalized or otherwise implemented and if it is, what impact it will have on our business.

Legislative changes in the Medicare program may also affect our business. For example, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 revised cost-sharing requirements for some beneficiaries and requires states to reimburse the federal Medicare program for costs of prescription drug coverage provided to beneficiaries who are enrolled simultaneously in both the Medicaid and Medicare programs. In addition, the Medicare prescription drug benefit interrupted the distribution of prescription drugs to many beneficiaries simultaneously enrolled in both Medicaid and Medicare, prompting several states to pay for prescription drugs on an unbudgeted, emergency basis without any assurance of receiving reimbursement from the federal Medicaid program. These expenses may cause some states to divert funds originally intended for other Medicaid services which could adversely affect our growth, operations and financial performance.

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

Our operations are conducted through our wholly owned subsidiaries, which include health maintenance organizations, or HMOs, and managed care organizations, or MCOs. HMOs and MCOs are subject to state

regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Additionally, state regulatory agencies may require, at their discretion, individual HMOs to maintain statutory capital levels higher than the state regulations. If this were to occur to one of our subsidiaries, we may be required to make additional capital contributions to the affected subsidiary. Any additional capital contribution made to one of the affected subsidiaries could have a material adverse effect on our liquidity and our ability to grow.

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

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

Risks Related to Our Business

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

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

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

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

We can not be sure that our medical claims liability estimates are adequate or that adjustments to those estimates will not unfavorably impact our results of operations. For example, in the three months ended September 30, 2006 we adjusted IBNR by $9.7 million for adverse medical costs development from the first quarter of 2006.

Additionally, when we commence operations in a new state or region, we have limited information with which to estimate our medical claims liability. For example, we commenced operations in South Carolina in December 2007 and began our Foster Care program in Texas in April 2008. For a period of time after the inception of business in these states, we based our estimates on state provided historical actuarial data and limited actual incurred and received claims.

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

Receipt of inadequate or significantly delayed premiums would negatively affect our revenues and profitability.

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

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

Table of Contents

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

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

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

As of September 30, 2009, we had $434.8 million in cash, cash equivalents and short-term investments and $504.2 million of long-term investments and restricted deposits. We maintain an investment portfolio of cash equivalents and short-term and long-term investments in a variety of securities which may include asset backed securities, bank deposits, commercial paper, certificates of deposit, money market funds, municipal bonds, corporate bonds, instruments of the U.S. Treasury, insurance contracts and equity securities. These investments are subject to general credit, liquidity, market and interest rate risks. Substantially all of these securities are subject to interest rate and credit risk and will decline in value if interest rates increase or one of the issuers' credit ratings is reduced. As a result, we may experience a reduction in value or loss of liquidity of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition. For example, in the third quarter of 2008, we recorded a loss on investments of approximately $4.5 million due to a loss in a money market fund.

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

As of September 30, 2009, we had $392.1 million of investments in state and municipal securities. These securities are not guaranteed by the United States government. State and municipal securities are subject to additional credit risk based upon each local municipality's tax revenues and financial stability. As a result, we may experience a reduction in value or loss of liquidity of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition.

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

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

We generally are required to obtain regulatory approval from one or more state agencies when making acquisitions. In the case of an acquisition of a business located in a state in which we do not currently operate, we would be required to obtain the necessary licenses to operate in that state. In addition, even if we already operate in a state in which we acquire a new business, we would be required to obtain additional regulatory approval if the

acquisition would result in our operating in an area of the state in which we did not operate previously, and we could be required to renegotiate provider contracts of the acquired business. We cannot provide any assurance that we would be able to comply with these regulatory requirements for an acquisition in a timely manner, or at all. In deciding whether to approve a proposed acquisition, state regulators may consider a number of factors outside our control, including giving preference to competing offers made by locally owned entities or by not-for-profit entities.

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

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

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

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

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

Additionally, our growth strategy includes start-up operations in new markets or new products in existing markets. We may incur significant expenses prior to commencement of operations and the receipt of revenue. As a result, these start-up operations may decrease our profitability. In the event we pursue any opportunity to diversify our business internationally, we would become subject to additional risks, including, but not limited to, political risk, an unfamiliar regulatory regime, currency exchange risk and exchange controls, cultural and language differences, foreign tax issues, and different labor laws and practices.

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

Acquisitions of unfamiliar new businesses could negatively impact our business.

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

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

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

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

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

Table of Contents

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

The securities and credit markets have been experiencing extreme volatility and disruption over the past year. The availability of credit, from virtually all types of lenders, has been severely restricted. Such conditions may persist throughout 2009, 2010 and beyond. In the event we need access to additional capital to pay our operating expenses, make payments on our indebtedness, pay capital expenditures, including costs related to our corporate headquarters' project, or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant, particularly if we are unable to access our existing credit facility.

Our access to additional financing will depend on a variety of factors such as prevailing economic and credit market conditions, the general availability of credit, the overall availability of credit to our industry, our credit ratings and credit capacity, and perceptions of our financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms or at all. We believe that if credit could be obtained, the terms and costs of such credit could be significantly less favorable to us than what was obtained in our most recent financings.

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

Operations in a few states have accounted for most of our premium revenues to date. If we were unable to continue to operate in any of our current states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our Medicaid contract with Kansas, which terminated December 31, 2006, together with our Medicaid contract with Missouri, accounted for $317.0 million in revenue for the year ended December 31, 2006. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on legislative or other governmental or regulatory actions and decisions, economic conditions and similar factors in those states. For example, states we currently serve may bid out their Medicaid program through a Request for Proposal, or RFP, process. Our inability to continue to operate in any of the states in which we operate would harm our business.

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

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

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

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

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

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

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

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

We may be unable to attract and retain key personnel.

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

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

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

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

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

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

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

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

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

Table of Contents

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If we are unable to complete the previously announced sale of certain of assets of our New Jersey health plan in a timely manner, our business could suffer.

On November 20, 2008, we announced that we had entered into an agreement with Amerigroup Corporation, or Amerigroup, to sell certain assets of our subsidiary University Health Plans, Inc. in the State of New Jersey to Amerigroup. The agreement contains a number of conditions to closing, including (i) the approval of regulators in New Jersey, (ii) the lack of a material adverse effect, and (iii) other customary conditions. On December 31, 2008, we announced that we had received a termination notice from Amerigroup relating to the New Jersey transaction. On October 23, 2009, we entered into a settlement agreement with Amerigroup resolving all claims. If we are unable to complete the sale of our New Jersey business, our results of operations could be negatively impacted.

Risks related to our corporate headquarters' project could harm our financial position, results of operations or cash flows.

In 2008, our capital expenditures included $27.0 million for land and fees associated with the construction of a real estate development on the property adjoining our corporate office, which we believe is necessary to accommodate our growing business. We are currently a joint venture partner in an entity that is developing the properties. If the entity is unable to complete the development or if the entity delays or abandons the real estate project, it may have an adverse impact on our financial position, results of operations or cash flows. For example, in 2007 we abandoned a previously planned redevelopment project and recorded a pre-tax impairment charge of $7.2 million. Our operations and efficiency could also be impacted if the development is not completed as there is limited office space for us to expand in the market near our existing headquarters as our business continues to grow.

Table of Contents

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

Issuer Purchases of Equity Securities 1
Third Quarter 2009

Period	Total Number of Shares Purchased 2	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
July 1 – July 31, 2009	4,565	$ 19.39	—	1,667,724
August 1 – August 31, 2009	195	18.13	—	1,667,724
September 1 – September 30, 2009	—	—	—	1,667,724
Total	4,760	$ 19.34	—	1,667,724

(1) Our Board of Directors adopted a stock repurchase program of up to 4,000,000 shares
(2) Shares acquired represent shares relinquished to the Company by certain employees for payment of taxes upon vesting of restricted stock units.

Table of Contents

ITEM 6. Exhibits.

Exhibits.

EXHIBIT NUMBER	DESCRIPTION
10.1*	Amendment M (Version 1.13) to Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.
12.1	Computation of ratio of earnings to fixed charges.
31.1	Certification of Chairman, President and Chief Executive Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Executive Vice President and Chief Financial Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chairman, President and Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Executive Vice President and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

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

Table of Contents

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized as of October 27, 2009.

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 Vice President, Corporate Controller and Chief Accounting Officer (principal accounting officer)