

Attachment B.31.d  
WellCare 10-Q Forms

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## **FORM 10-Q**

**WELLCARE HEALTH PLANS, INC. - WCG**

**Filed: May 06, 2010 (period: March 31, 2010)**

Quarterly report which provides a continuing view of a company's financial position

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**UNITED STATES**  
**SECURITIES AND EXCHANGE COMMISSION**  
Washington, D.C. 20549  
**FORM 10-Q**

(Mark One)

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

For the quarterly period ended **March 31, 2010**  
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: **001-32209**

**WELLCARE HEALTH PLANS, INC.**

(Exact name of registrant as specified in its charter)

**Delaware**  
(State or other jurisdiction of  
incorporation or organization)

**47-0937650**  
(I.R.S. Employer  
Identification No.)

**8725 Henderson Road, Renaissance One**  
**Tampa, Florida**  
(Address of principal executive offices)

**33634**  
(Zip Code)

**(813) 290-6200**  
(Registrant's telephone number, including area code)

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. 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 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 "smaller reporting company" in Rule 12b-2 of the Exchange Act

Large accelerated filer  Accelerated filer  Non-accelerated filer  Smaller reporting company   
(Do not check if a 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

As of May 3, 2010 there were 42,390,665 shares of the registrant's common stock, par value \$.01 per share, outstanding.

WELLCARE HEALTH PLANS, INC.

TABLE OF CONTENTS

|                                       | <u>Page</u>  |    |
|---------------------------------------|--|----|
| <b>Part I — FINANCIAL INFORMATION</b> |  |    |
| Item 1.                               | Financial Statements   |    |
|                                       | Condensed Consolidated Balance Sheets at March 31, 2010 (unaudited) and December 31, 2009                      | 2  |
|                                       | Condensed Consolidated Statements of Operations for the three months ended March 31, 2010 and 2009 (unaudited) | 3  |
|                                       | Condensed Consolidated Statements of Cash Flows for the three months ended March 31, 2010 and 2009 (unaudited) | 4  |
|                                       | Notes to Condensed Consolidated Financial Statements (unaudited)   | 5  |
| Item 2.                               | Management's Discussion and Analysis of Financial Condition and Results of Operations                          | 13 |
| Item 3.                               | Quantitative and Qualitative Disclosures About Market Risk   | 24 |
| Item 4.                               | Controls and Procedures  | 24 |
| <b>Part II — OTHER INFORMATION</b>    |  |    |
| Item 1.                               | Legal Proceedings  | 25 |
| Item 1A.                              | Risk Factors   | 25 |
| Item 2.                               | Unregistered Sales of Equity Securities and Use of Proceeds  | 26 |
| Item 6.                               | Exhibits   | 26 |
| Signatures                            |  |    |

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Part I — FINANCIAL INFORMATION

Item 1. Financial Statements.

WELLCARE HEALTH PLANS, INC.  
CONDENSED CONSOLIDATED BALANCE SHEETS  
(In thousands, except share data)

|  | <u>March 31,</u><br><u>2010</u> | <u>December 31,</u><br><u>2009</u> |
|--|---------------------------------|------------------------------------|
|  | (Unaudited)                     |                                    |
| <b>Assets</b>  |                                 |                                    |
| Current Assets:  |                                 |                                    |
| Cash and cash equivalents  | \$ 1,027,337                    | \$ 1,158,131                       |
| Investments  | 56,818                          | 62,722                             |
| Premium and other receivables, net   | 262,027                         | 285,808                            |
| Funds receivable for the benefit of members  | 43,832                          | 77,851                             |
| Taxes recoverable  | 6,767                           | —                                  |
| Prepaid expenses and other current assets, net   | 107,064                         | 104,079                            |
| Deferred income taxes  | 21,563                          | 28,874                             |
| Total current assets   | <u>1,525,408</u>                | <u>1,717,465</u>                   |
| Property, equipment and capitalized software, net  | 67,077                          | 61,785                             |
| Goodwill   | 111,131                         | 111,131                            |
| Other intangible assets, net   | 12,578                          | 12,961                             |
| Long-term investments  | 45,640                          | 51,710                             |
| Restricted investments   | 130,486                         | 130,550                            |
| Deferred tax asset   | 14,524                          | 18,745                             |
| Other assets   | 10,715                          | 14,100                             |
| Total Assets   | <u>\$ 1,917,559</u>             | <u>\$ 2,118,447</u>                |
| <b>Liabilities and Stockholders' Equity</b>  |                                 |                                    |
| Current Liabilities:   |                                 |                                    |
| Medical benefits payable   | \$ 706,825                      | \$ 802,515                         |
| Unearned premiums  | 143                             | 90,496                             |
| Accounts payable   | 6,930                           | 5,270                              |
| Other accrued expenses and liabilities   | 199,729                         | 219,691                            |
| Current portion of amounts accrued related to investigation resolution   | 18,175                          | 18,192                             |
| Other payables to government partners  | 42,694                          | 38,147                             |
| Taxes payable  | —                               | 4,888                              |
| Other current liabilities  | 871                             | 871                                |
| Total current liabilities  | <u>975,367</u>                  | <u>1,180,070</u>                   |
| Amounts accrued related to investigation resolution  | 40,733                          | 40,205                             |
| Other liabilities  | 17,853                          | 17,272                             |
| Total liabilities  | <u>1,033,953</u>                | <u>1,237,547</u>                   |
| Commitments and contingencies (see Note 5)   | —                               | —                                  |
| Stockholders' Equity:  |                                 |                                    |
| Preferred stock, \$0.01 par value (20,000,000 authorized, no shares issued or outstanding)   | —                               | —                                  |
| Common stock, \$0.01 par value (100,000,000 authorized, 42,413,593 and 42,361,207 shares issued and outstanding at March 31, 2010 and December 31, 2009, respectively) | 424                             | 424                                |
| Paid-in capital  | 421,220                         | 425,083                            |
| Retained earnings  | 464,930                         | 458,512                            |
| Accumulated other comprehensive loss   | (2,968)                         | (3,119)                            |
| Total stockholders' equity   | <u>883,606</u>                  | <u>880,900</u>                     |
| Total Liabilities and Stockholders' Equity   | <u>\$ 1,917,559</u>             | <u>\$ 2,118,447</u>                |

See notes to unaudited condensed consolidated financial statements.

**WELLCARE HEALTH PLANS, INC.**  
**CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS**  
(Unaudited, in thousands, except per share data)

|  | <b>Three Months Ended</b> |              |
|--|---------------------------|--------------|
|  | <b>March 31,</b>          |              |
|  | <b>2010</b>               | <b>2009</b>  |
| Revenues:  |                           |              |
| Premium  | \$ 1,353,458              | \$ 1,791,927 |
| Investment and other income                      | 2,495                     | 3,334        |
| Total revenues                                   | 1,355,953                 | 1,795,261    |
| Expenses:  |                           |              |
| Medical benefits                                 | 1,165,972                 | 1,552,998    |
| Selling, general and administrative              | 173,337                   | 271,741      |
| Depreciation and amortization                    | 5,756                     | 5,739        |
| Interest   | 10                        | 2,066        |
| Total expenses                                   | 1,345,075                 | 1,832,544    |
| Income (loss) before income taxes                | 10,878                    | (37,283)     |
| Income tax expense (benefit)                     | 4,460                     | (350)        |
| Net income (loss)                                | \$ 6,418                  | \$ (36,933)  |
| Net income (loss) per common share (see Note 1): |                           |              |
| Basic  | \$ 0.15                   | \$ (0.89)    |
| Diluted  | \$ 0.15                   | \$ (0.89)    |

*See notes to unaudited condensed consolidated financial statements.*

**WELLCARE HEALTH PLANS, INC.**  
**CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS**  
(Unaudited, in thousands)

|  | <b>Three Months Ended March 31,</b> |              |
|--|-------------------------------------|--------------|
|  | <b>2010</b>                         | <b>2009</b>  |
| Cash from (used in) operating activities:  |                                     |              |
| Net income (loss)  | \$ 6,418                            | \$ (36,933)  |
| Adjustments to reconcile net income (loss) to net cash provided by operating activities: |                                     |              |
| Depreciation and amortization  | 5,756                               | 5,739        |
| Equity-based compensation expense  | 1,142                               | 9,612        |
| Deferred taxes, net  | 11,532                              | (318)        |
| Changes in operating accounts:   |                                     |              |
| Premium and other receivables, net   | 23,781                              | (69,876)     |
| Other receivables from government partners, net  | —                                   | (50,689)     |
| Prepaid expenses and other current assets, net   | (2,985)                             | 4,907        |
| Medical benefits payable   | (95,690)                            | 113,622      |
| Unearned premiums  | (90,353)                            | (62,554)     |
| Accounts payable and other accrued expenses  | (18,466)                            | (87,028)     |
| Other payables to government partners  | 4,547                               | 22,912       |
| Amounts accrued related to investigation resolution                                      | 511                                 | 44,800       |
| Taxes, net   | (14,401)                            | 2,288        |
| Other, net   | (2,336)                             | (2,236)      |
| Net cash used in operations  | (170,544)                           | (105,754)    |
| Cash from (used in) investing activities:  |                                     |              |
| Purchases of investments   | (117)                               | (18,756)     |
| Proceeds from sales and maturities of investments  | 12,322                              | 19,051       |
| Purchases of restricted investments  | (289)                               | (17,088)     |
| Proceeds from maturities of restricted investments                                       | 368                                 | 39,390       |
| Additions to property, equipment and capitalized software, net                           | (4,235)                             | (5,141)      |
| Net cash provided by investing activities  | 8,049                               | 17,456       |
| Cash from (used in) financing activities:  |                                     |              |
| Proceeds from option exercises and other   | 770                                 | —            |
| Purchase of treasury stock   | (3,030)                             | (1,432)      |
| Payments on debt   | —                                   | (400)        |
| Payments on capital leases   | (58)                                | —            |
| Funds received for the benefit of members  | 34,019                              | 42,788       |
| Net cash provided by financing activities  | 31,701                              | 40,956       |
| Cash and cash equivalents:   |                                     |              |
| Decrease during the period   | (130,794)                           | (47,342)     |
| Balance at beginning of year   | 1,158,131                           | 1,181,922    |
| Balance at end of period   | \$ 1,027,337                        | \$ 1,134,580 |
| <b>SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION:</b>                                |                                     |              |
| Cash paid for taxes  | \$ 8,161                            | \$ 903       |
| Cash paid for interest   | \$ 7                                | \$ 1,790     |
| Property, equipment and capitalized software acquired through capital leases             | \$ 8,411                            | \$ —         |

*See notes to unaudited condensed consolidated financial statements.*

**WELLCARE HEALTH PLANS, INC.**

**NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS**

**(Unaudited, in thousands, except member, per share and share data)**

**1. ORGANIZATION, BASIS OF PRESENTATION AND SIGNIFICANT ACCOUNTING POLICIES**

WellCare Health Plans, Inc., a Delaware corporation (the “Company,” “we,” “us,” or “our”), provides managed care services exclusively to government-sponsored health care programs, focusing on Medicaid and Medicare, including health plans for families, children, and the aged, blind and disabled, serving approximately 2,186,000 members nation-wide as of March 31, 2010. Our Medicaid plans include plans for recipients of the Temporary Assistance for Needy Families (“TANF”) programs, Supplemental Security Income (“SSI”) programs, Aged Blind and Disabled (“ABD”) programs, Children’s Health Insurance Programs (“CHIP”) and the Family Health Plus (“FHP”) programs. Through our licensed subsidiaries, as of March 31, 2010, we operated our Medicaid health plans in Florida, Georgia, Hawaii, Illinois, Missouri, New York and Ohio. Our Medicare plans include stand-alone prescription drug plans (“PDPs”) as a part of our PDP segment and Medicare Advantage (“MA”) plans as a part of our MA segment, which following our exit of the Medicare private fee-for-service (“PFFS”) program on December 31, 2009, is comprised of Medicare coordinated care plans (“CCPs”). As of March 31, 2010, we offered our CCPs in Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Louisiana, Missouri, New Jersey, New York, Ohio and Texas, and our PDPs in 49 states and the District of Columbia.

***Basis of Presentation***

The accompanying unaudited condensed consolidated interim financial statements should be read in conjunction with the consolidated financial statements and notes thereto for the fiscal year ended December 31, 2009 included in our Annual Report on Form 10-K (“2009 Form 10-K”), filed with the United States Securities and Exchange Commission (the “SEC”) in February 2010. In the opinion of management, the interim financial statements reflect all normal recurring adjustments that we consider necessary for the fair presentation of our financial position, results of operations and cash flows for the interim periods presented. The interim financial statements included herein have been prepared in accordance with accounting principles generally accepted in the United States of America (“GAAP”) and with the instructions to Form 10-Q and Article 10 of Regulation S-X. Accordingly, certain information and footnote disclosures normally included in financial statements prepared in accordance with GAAP have been condensed or omitted. Results for the interim periods presented are not necessarily indicative of results that may be expected for the entire year or any other interim period. In addition, we have evaluated all material events subsequent to the date of our financial statements.

***Net Income (Loss) per Share***

We compute basic net income (loss) per common share on the basis of the weighted-average number of unrestricted common shares outstanding. Diluted net income (loss) per common share is computed on the basis of the weighted-average number of unrestricted common shares outstanding plus the dilutive effect of outstanding stock options, restricted shares and restricted stock units using the treasury stock method. The following table presents the calculation of net income (loss) per common share — basic and diluted:

|  | <b>Three Months Ended</b> |                   |
|--|---------------------------|-------------------|
|  | <b>March 31,</b>          |                   |
|  | <b>2010</b>               | <b>2009</b>       |
| <b>Numerator:</b>                                    |                           |                   |
| Net income (loss)                                    | \$ 6,418                  | \$ (36,933)       |
| <b>Denominator:</b>                                  |                           |                   |
| Weighted-average common shares outstanding — basic   | 42,193,662                | 41,680,319        |
| Dilutive effect of:                                  |                           |                   |
| Unvested restricted stock and stock units            | 360,043                   | —                 |
| Stock options  | 153,536                   | —                 |
| Weighted-average common shares outstanding — diluted | <u>42,707,241</u>         | <u>41,680,319</u> |
| <b>Net income (loss) per common share:</b>           |                           |                   |
| Basic  | \$ 0.15                   | \$ (0.89)         |
| Diluted  | \$ 0.15                   | \$ (0.89)         |

Certain options to purchase common stock were not included in the calculation of diluted net income (loss) per common share because their exercise prices were greater than the average market price of our common stock for the period and, therefore, the effect would be anti-dilutive. For the three months ended March 31, 2010, approximately 119,356 restricted equity awards as well as 1,165,606 options with exercise prices ranging from \$24.17 to \$91.64 per share were excluded from diluted weighted-average common shares outstanding. Due to the net loss for the three months ended March 31, 2009, the assumed exercise of 5,115,297 equity awards had an anti-dilutive effect and was therefore excluded from the computation of diluted loss per share.

### ***Recently Issued Accounting Standards***

In February 2010, the Financial Accounting Standards Board (the “FASB”) issued authoritative guidance related to subsequent events. This standard updates subsequent event guidance, issued in May 2009, requiring reporting entities to provide the date through which subsequent event reviews occurred, which was in conflict with certain SEC requirements. Accordingly, the update to previously issued subsequent event guidance removes the requirement to disclose a date through which subsequent events have been evaluated. The adoption of this guidance did not have a material effect on our financial statements.

In January 2010, the FASB issued authoritative guidance related to improving disclosures about fair value measurements. This standard requires reporting entities to make new disclosures about recurring or nonrecurring fair-value measurements including significant transfers into and out of Level 1 and Level 2 fair value measurements and information on purchases, sales, issuances and settlements on a gross basis in the reconciliation of Level 3 fair value measurements. This standard is effective for annual reporting periods beginning after December 15, 2009, except for Level 3 reconciliation disclosures which are effective for annual periods beginning after December 15, 2010. The adoption of this guidance has not had a material impact on our financial statements.

## **2. SEGMENT REPORTING**

Reportable operating segments are defined as components of an enterprise for which discrete financial information is available and evaluated on a regular basis by the chief operating decision-maker to determine how resources should be allocated to an individual segment and to assess performance of those segments. Previously, we reported two operating segments: Medicaid and Medicare, which coincide with our two main business lines. During the first quarter of 2010, we reassessed our segment reporting practices and made revisions to reflect our current method of managing performance and determining resource allocation, which includes reviewing the results of our PDP operations separately from other Medicare products. Accordingly, we now have three reportable segments within our two main business lines: Medicaid, MA and PDP. The PFFS product that we exited December 31, 2009 is reported within the MA segment. The prior periods have been revised to reflect this segment presentation.

Medicaid was established to provide medical assistance to low-income and disabled persons. It is state operated and implemented, although it is funded and regulated by both the state and federal governments. Our Medicaid segment includes plans for beneficiaries of TANF, SSI, ABD, CHIP and FHP. TANF generally provides assistance to low-income families with children, and SSI generally provides assistance to low-income aged, blind or disabled individuals. Our Medicaid segment also includes other programs that are not part of the Medicaid program, such as CHIP and FHP, for qualifying families who are not eligible for Medicaid because they exceed the applicable income thresholds.

Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons with a variety of hospital, medical insurance and prescription drug benefits.

Our MA segment includes MA plans, which following the exit of our PFFS product on December 31, 2009, is comprised of CCPs. MA is Medicare’s managed care alternative to original Medicare fee-for-service, which provides individuals standard Medicare benefits directly through the Centers for Medicare & Medicaid Services (“CMS”). CCPs are administered through health maintenance organizations (“HMOs”) and generally require members to seek health care services from a network of health care providers. In addition, we offer Medicare Part D coverage, which provides prescription drug benefits, as a component of our MA plans.

We offer stand-alone Medicare Part D coverage to Medicare eligible beneficiaries in our PDP segment. The Medicare Part D prescription drug benefit is supported by risk-sharing with the federal government through risk corridors designed to limit the losses and gains of the drug plans and by reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for risk factor payments. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries. The Part D program offers national in-network prescription drug coverage that is subject to limitations in certain circumstances.

Balance sheet, Investment and other income, and other expense details by segment have not been disclosed, as they are not reported internally by us.

|                                   | <b>Three Months Ended<br/>March 31,</b> |                    |
|-----------------------------------|---|--------------------|
|                                   | <b>2010</b>                             | <b>2009</b>        |
| Premium revenue:                  |   |                    |
| Medicaid                          | \$ 809,033                              | \$ 809,178         |
| Medicare Advantage                | 351,083                                 | 733,099            |
| PDP                               | 193,342                                 | 249,650            |
| Total premium revenue             | <u>1,353,458</u>                        | <u>1,791,927</u>   |
| Medical benefits expense:         |   |                    |
| Medicaid                          | 701,779                                 | 689,782            |
| Medicare Advantage                | 276,175                                 | 611,730            |
| PDP                               | 188,018                                 | 251,486            |
| Total medical benefits expense    | <u>1,165,972</u>                        | <u>1,552,998</u>   |
| Gross margin:                     |   |                    |
| Medicaid                          | 107,254                                 | 119,396            |
| Medicare Advantage                | 74,908                                  | 121,368            |
| PDP                               | 5,324                                   | (1,835)            |
| Total gross margin                | <u>187,486</u>                          | <u>238,929</u>     |
| Investment and other income       | 2,495                                   | 3,334              |
| Other expenses                    | (179,103)                               | (279,546)          |
| Income (loss) before income taxes | <u>\$ 10,878</u>                        | <u>\$ (37,283)</u> |

### 3. EQUITY-BASED COMPENSATION

The compensation expense recorded related to our equity-based compensation awards, which correspondingly also increased Paid-in capital, for the three months ended March 31, 2010 and 2009 was \$1,142 and \$9,612, respectively. Under the 2004 Equity Incentive Plan, we granted shares to a former executive, the vesting of which and the amount of shares to be awarded was contingent upon achievement of an earnings per share target over three- and five-year performance periods. The earnings per share target for the first performance period was achieved. However, in accordance with the separation agreement between the former executive and us, issuance of those shares is subject to certain conditions that we have determined, based on recent developments, have not been, and are unlikely to be, met. Accordingly, the previously recorded compensation cost of \$4,683 was reversed during the three months ended March 31, 2010.

A summary of our restricted stock, restricted stock unit ("RSU") and stock option activity for the three months ended March 31, 2010 is presented in the table below.

|                                   | <b>Restricted<br/>Stock<br/>and RSU</b> | <b>Weighted<br/>Average<br/>Grant-Date<br/>Fair Value</b> | <b>Options</b>   | <b>Weighted<br/>Average<br/>Exercise Price</b> |
|-----------------------------------|---|---|------------------|--|
| Outstanding as of January 1, 2010 |   | \$  |                  | \$   |
|                                   | 1,339,981                               | 29.30   | 1,919,535        | 35.26  |
| Granted                           | 180,778                                 | 30.00   | 101,594          | 28.90  |
| Exercised                         | —                                       | —   | (40,193)         | 18.55  |
| Vested                            | (134,911)                               | 34.17   | —                | —  |
| Forfeited and expired             | (75,610)                                | 34.68   | (190,328)        | 46.06  |
| Outstanding at March 31, 2010     | <u>1,310,238</u>                        | 30.64   | <u>1,790,608</u> | 34.12  |
| Exercisable at March 31, 2010     | n/a                                     | n/a   | <u>1,120,996</u> | 38.21  |

As of March 31, 2010, there was \$41,826 of unrecognized compensation cost related to non-vested equity-based compensation arrangements that is expected to be recognized over a weighted-average period of 2.1 years.

### ***Performance Stock Units***

On March 31, 2010, the Compensation Committee of the Board of Directors awarded 168,235 Performance Stock Unit Awards (the "2010 PSU Awards") under the 2004 Equity Incentive Plan to certain of our key employees, including executive officers. The 2010 PSU Awards vest three years from the date of grant and are subject to adjustment in the target range of 0% to 150%, based on the achievement of certain financial and quality-based performance goals set by the Compensation Committee over the three-year performance period and the employee's continued service through the vest date. The actual number of PSU's that vest will be determined by the Compensation Committee at its sole discretion. The estimated future grant date fair value of the 2010 PSU Awards ultimately expected to vest will be recognized as expense over the three-year performance period based on estimated progress towards the performance measures, as well as subsequent changes in the market price of our common stock.

## **4. FAIR VALUE MEASUREMENTS**

Fair value measurements apply to all financial assets and financial liabilities that are being measured and reported on a fair value basis. Accounting standards require that fair value measurements be classified and disclosed in one of the following three categories: Level 1, defined as observable inputs such as quoted prices in active markets; Level 2, defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

Our Condensed Consolidated Balance Sheets include the following financial instruments: cash and cash equivalents, investments, receivables, accounts payable, medical benefits payable and amounts accrued related to the investigation resolution discussed in Note 5 to these Condensed Consolidated Financial Statements. The carrying amounts of current assets and liabilities approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization.

Our Long-term investments were comprised of \$50,700 and \$57,000 of municipal note investments with an auction reset feature ("auction rate securities"), at amortized cost, as of March 31, 2010 and December 31, 2009, respectively. Liquidity for these auction rate securities is typically provided by an auction process which allows holders to sell their notes and resets the applicable interest rate at pre-determined intervals, usually every seven, 14, 28 or 35 days. Auctions for these auction rate securities continued to fail during the three months ended March 31, 2010. An auction failure means that the parties wishing to sell their securities could not be matched with an adequate volume of buyers. As a result, our ability to liquidate and fully recover the carrying value of our remaining auction rate securities in the near term may be limited or non-existent. However, when there is a failed auction, the indenture governing the security requires the issuer to pay interest at a contractually defined rate that is generally above market rates for other types of similar instruments. Additionally, there are government guarantees or municipal bond insurance in place and we have the ability and the present intent to hold these securities until maturity or market stability is restored. Accordingly, we do not believe our auction rate securities are impaired and as a result, we have not recorded any impairment losses for our auction rate securities. However, as these securities are believed to be in an inactive market, we have estimated the fair value of these securities using a discounted cash flow model. This model considered, among other things, the collateralization underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties.

Our assets and liabilities measured at fair value on a recurring basis subject to the disclosure requirements of fair value accounting guidance as of March 31, 2010 and December 31, 2009, respectively, were as follows:

**Fair Value Measurements at March 31, 2010 Using:**

| Description  | March 31,<br>2010 | Fair Value Measurements at March 31, 2010 Using:                        |   |  |
|--|-------------------|---|---|--|
|  |                   | Quoted Prices in<br>Active Markets for<br>Identical Assets<br>(Level 1) | Significant<br>Other<br>Observable<br>Inputs<br>(Level 2) | Significant<br>Unobservable<br>Inputs<br>(Level 3) |
| Investments:   |                   |   |   |  |
| Available-for-sale securities                          |                   |   |   |  |
|  |                   |   | \$  |  |
| Certificates of deposit                                | \$ 53,003         | \$ 53,003   | —\$   | —  |
| Auction rate securities                                | 45,640            | —   | —   | 45,640   |
| Other municipal variable rate bonds                    | 3,815             | 3,815   | —   | —  |
|  |                   |   | \$  |  |
| Total investments                                      | \$ 102,458        | \$ 56,818   | —\$   | 45,640   |
| Restricted investments:                                |                   |   |   |  |
| Available-for-sale securities                          |                   |   |   |  |
|  |                   |   | \$  |  |
| Cash and cash equivalents                              | \$ 4,601          | \$ 4,601  | —\$   | —  |
| Certificates of deposit                                | 1,051             | 1,051   | —   | —  |
| U.S. Government securities                             | 20,951            | 20,951  | —   | —  |
| Money market funds                                     | 103,883           | 103,883   | —   | —  |
|  |                   |   | \$  |  |
| Total restricted investments                           | \$ 130,486        | \$ 130,486  | —\$   | —  |
| Amounts accrued related to investigation resolution(1) |                   |   |   |  |
|  | \$ 58,908         | —   | \$ 58,908   | —  |

**Fair Value Measurements at December 31, 2009 Using:**

| Description  | December 31,<br>2009 | Fair Value Measurements at December 31, 2009 Using:                        |   |  |
|--|----------------------|--|---|--|
|  |                      | Quoted Prices in<br>Active Markets<br>for<br>Identical Assets<br>(Level 1) | Significant<br>Other<br>Observable<br>Inputs<br>(Level 2) | Significant<br>Unobservable<br>Inputs<br>(Level 3) |
| Investments:   |                      |  |   |  |
| Available-for-sale securities                          |                      |  |   |  |
|  | \$                   | \$   | \$  |  |
| Certificates of deposit                                | 58,907               | 58,907   | — \$  | —  |
| Auction rate securities                                | 51,710               | —  | —   | 51,710   |
| Other municipal variable rate bonds                    | 3,815                | 3,815  | —   | —  |
|  | \$                   | \$   | \$  |  |
| Total investments                                      | 114,432              | 62,722   | — \$  | 51,710   |
| Restricted investments:                                |                      |  |   |  |
| Available-for-sale securities                          |                      |  |   |  |
|  | \$                   | \$   | \$  |  |
| Cash and cash equivalents                              | 4,651                | 4,651  | — \$  | —  |
| Certificates of deposit                                | 1,051                | 1,051  | —   | —  |
| U.S. Government securities                             | 20,975               | 20,975   | —   | —  |
| Money market funds                                     | 103,873              | 103,873  | —   | —  |
|  | \$                   | \$   | \$  |  |
| Total restricted investments                           | 130,550              | 130,550  | — \$  | —  |
| Amounts accrued related to investigation resolution(1) |                      |  |   |  |
|  | \$ 58,397            | —  | \$ 58,397   | —  |

(1) These amounts are included in the short- and long-term portions of amounts accrued related to investigation resolution line items in our Condensed Consolidated Balance Sheets as of March 31, 2010 and December 31, 2009, respectively.



The following tables present our auction rate securities measured at fair value on a recurring basis using significant unobservable inputs (i.e., Level 3 data) as of March 31, 2010 and December 31, 2009, respectively.

|   | <b>Fair Value<br/>Measurements<br/>Using Significant<br/>Unobservable<br/>Inputs(Level 3)</b> |
|---|---|
| Beginning balance at January 1, 2010                                | \$ 51,710   |
| Realized gains (losses) in earnings (or changes in net assets)      | —   |
| Unrealized gains (losses) included in other comprehensive income(a) | 230   |
| Purchases, issuances and settlements(b)                             | (6,300)   |
| Transfers in and/or out of Level 3                                  | —   |
| Ending balance at March 31, 2010                                    | <u>\$ 45,640</u>  |

(a) As a result of the increase in the fair value of our investments in auction rate securities, we recorded a net unrealized gain of \$230 to Accumulated other comprehensive loss during 2010. The increase in unrealized gain was driven by the stabilization and improvement within the municipal bond market during 2010.

(b) A \$6,300 auction rate security tranche was redeemed by the issuer at par in March 2010. Accordingly, we recorded an adjustment to the fair market valuation of the issuer's auction rate securities during the first quarter of 2010.

|   | <b>Fair Value<br/>Measurements<br/>Using Significant<br/>Unobservable<br/>Inputs<br/>(Level 3)</b> |
|---|--|
| Beginning balance at January 1, 2009                                | \$ 54,972  |
| Realized gains (losses) in earnings (or changes in net assets)      | —  |
| Unrealized gains (losses) included in other comprehensive income(a) | 1,138  |
| Purchases, issuances and settlements(b)                             | (4,400)  |
| Transfers in and/or out of Level 3                                  | —  |
| Ending balance at December 31, 2009                                 | <u>\$ 51,710</u>   |

(a) As a result of the increase in the fair value of our investments in auction rate securities, we recorded a net unrealized gain of \$1,138 to Accumulated other comprehensive loss during 2009. The increase in unrealized gain was driven by the stabilization and improvement within the municipal bond market during 2009.

(b) A \$4,400 auction rate security tranche was redeemed by the issuer at par in February 2009. Accordingly, we recorded an adjustment to the fair market valuation of the issuer's auction rate securities during the first quarter of 2009.

## 5. COMMITMENTS AND CONTINGENCIES

### *Government Investigations*

As previously disclosed, in May 2009, we entered into a Deferred Prosecution Agreement (the "DPA") with the United States Attorney's Office for the Middle District of Florida (the "USAO") and the Florida Attorney General's Office, resolving previously disclosed investigations by those offices.

Under the one-count criminal information (the "Information") filed with the United States District Court for the Middle District of Florida (the "Court") by the USAO pursuant to the DPA, we were charged with one count of conspiracy to commit health care fraud against the Florida Medicaid Program in connection with reporting of expenditures under certain community behavioral health contracts, and against the Florida Healthy Kids programs, under certain contracts, in violation of 18 U.S.C. Section 1349. The USAO recommended to the Court that the prosecution of us be deferred for the duration of the DPA. Within five days of the expiration of the DPA the USAO will seek dismissal with prejudice of the Information, provided we have complied with the DPA.

The term of the DPA is thirty-six months, but such term may be reduced by the USAO to twenty-four months upon consideration of certain factors set forth in the DPA, including our continued remedial actions and compliance with all federal and state health care laws and regulations.

In accordance with the DPA, the USAO has filed, with the Court, a statement of facts relating to this matter. As a part of the DPA, we have retained an independent monitor (the "Monitor") for a period of 18 months from his retention in August 2009. The Monitor was selected by the USAO after consultation with us and is retained at our expense. In addition, we agreed to continue undertaking remedial measures to ensure full compliance with all federal and state health care laws. Among other things, the Monitor is reviewing our compliance with the DPA and all applicable federal and state health care laws, regulations and programs. The Monitor also is reviewing, evaluating and, as necessary, making written recommendations concerning certain of our policies and procedures. The DPA provides that the Monitor will undertake to avoid the disruption of our ordinary business operations or the imposition of unnecessary costs or expenses.

The DPA does not, nor should it be construed to, operate as a settlement or release of any civil or administrative claims for monetary, injunctive or other relief against us, whether under federal, state or local statutes, regulations or common law. Furthermore, the DPA does not operate, nor should it be construed, as a concession that we are entitled to any limitation of our potential federal, state or local civil or administrative liability. Pursuant to the terms of the DPA, we have paid the USAO a total of \$80,000.

In May 2009, we resolved the previously disclosed investigation by the SEC. Under the terms of the Consent and Final Judgment, without admitting or denying the allegations in the complaint filed by the SEC, we consented to the entry of a permanent injunction against any future violations of certain specified provisions of the federal securities laws. In addition, we agreed to pay, in four installments, a civil penalty in the aggregate amount of \$10,000 and disgorgement in the amount of one dollar plus post-judgment interest. As of March 31, 2010, \$2,500 was included in the Current portion of amounts accrued related to investigation resolution line item in our Condensed Consolidated Balance Sheet. This fourth and final installment was paid in May 2010.

As previously disclosed, we remain engaged in resolution discussions as to matters under review with the U.S. Department of Justice's Civil Division (the "Civil Division") and the U.S. Department of Health and Human Services' Office of Inspector General (the "OIG"). Those discussions are ongoing and no final resolution has been reached. In October 2008, the Civil Division informed us that as part of the pending civil inquiry, the Civil Division is investigating a number of *qui tam* complaints filed by relators against us under the whistleblower provisions of the False Claims Act, 31 U.S.C. sections 3729-3733. The seal in those cases has been partially lifted for the purpose of authorizing the Civil Division to disclose to us the existence of the *qui tam* complaints. In May 2010, as part of the ongoing resolution discussions with the Civil Division, we were provided a copy of these complaints, in response to our request, which otherwise remain under seal as required by 31 U.S.C. section 3730(b)(3). In connection with the ongoing resolution discussions with the Civil Division, we are addressing the allegations by the *qui tam* relators. We also learned from a docket search that a former employee filed a *qui tam* action on October 25, 2007 in state court for Leon County, Florida against several defendants, including us and one of our subsidiaries. It is possible that additional *qui tam* actions have been filed against us and are under seal. Thus, it is possible that we are subject to liability exposure under the False Claims Act, or similar state statutes, based on *qui tam* actions other than those discussed in this Form 10-Q or our 2009 Form 10-K. Management has accrued a liability of approximately \$60,000, discounted and recorded at its fair value of approximately \$56,408, for the resolution of these matters. We anticipate any settlement amounts would be payable in installments over a period of four to five years. This amount has been included in the current and long-term portions of amounts accrued related to the investigation resolution in our Condensed Consolidated Balance Sheet as of March 31, 2010. The actual outcome of these matters may differ materially from our judgment.

In addition, we are responding to subpoenas issued by the State of Connecticut Attorney General's Office involving transactions between us and our affiliates and their potential impact on the costs of Connecticut's Medicaid program. We have communicated with regulators in states in which our HMO and insurance operating subsidiaries are domiciled regarding the investigations, and we are cooperating with federal and state regulators and enforcement officials in all of these matters. We do not know whether, or the extent to which, any pending investigations might lead to the payment of fines or penalties, the imposition of injunctive relief and/or operating restrictions.

### ***Class Action and Derivative Lawsuits***

Putative class action complaints were filed in October 2007 and in November 2007. These putative class actions, entitled Eastwood Enterprises, L.L.C. v. Farha, et al. and Hutton v. WellCare Health Plans, Inc. et al., respectively, were filed in the United States District Court for the Middle District of Florida against us, Todd Farha, our former chairman and chief executive officer, and Paul Behrens, our former senior vice president and chief financial officer. Messrs. Farha and Behrens were also officers of various subsidiaries of ours. The Eastwood Enterprises complaint alleges that the defendants materially misstated our reported financial condition by, among other things, purportedly overstating revenue and understating expenses in amounts unspecified in the pleading in violation of the Securities Exchange Act of 1934, as amended ("Exchange Act"). The Hutton complaint alleges that various public statements supposedly issued by the defendants were materially misleading because they failed to disclose that we were purportedly operating our business in a potentially illegal and improper manner in violation of applicable federal guidelines and regulations. The complaint asserts claims under the Exchange Act. Both complaints seek, among other things, certification as a class action and damages. The two actions were consolidated, and various parties and law firms filed motions seeking to be designated as Lead Plaintiff and Lead Counsel. In an Order issued in March 2008, the Court appointed a group of five public pension funds from New Mexico, Louisiana and Chicago (the "Public Pension Fund Group") as Lead Plaintiffs. In October 2008, an amended consolidated complaint was filed in this class action asserting claims against us, Messrs. Farha and Behrens, and adding Thaddeus Bereday, our former senior vice president and general counsel, as a defendant. In January 2009, we and certain other defendants filed a joint motion to dismiss the amended consolidated complaint, arguing, among other things, that the complaint failed to allege a material misstatement by defendants with respect to our compliance with marketing and other health care regulations and failed to plead facts raising a strong inference of scienter with respect to all aspects of the purported fraud claim. The court denied the motion in September 2009 and we and the other defendants filed our answer to the amended consolidated complaint in November 2009. In April 2010, the Lead Plaintiffs filed their motion for class certification. Discovery is ongoing.

Separately, in October 2009, an action was filed against us in the Court of Chancery of the State of Delaware entitled Behrens, et al. v. WellCare Health Plans, Inc. in which the plaintiffs, Messrs. Behrens, Bereday, and Farha, seek an order requiring us to pay their respective expenses, including attorney fees, in connection with litigation and investigations in which the plaintiffs are involved by reason of their service as our directors and officers. Plaintiffs further challenge our right, prior to advancing such expenses, to first submit their expense invoices to our directors' and officers' insurance carrier for their preliminary review and evaluation of the adequacy of the description of services in the invoices and of the reasonableness of those expenses. We intend to defend ourselves vigorously against these claims. At this time, neither we nor any of our subsidiaries can predict the probable outcome of these claims. Accordingly, no amounts have been accrued in our condensed consolidated financial statements in respect to these matters.

As previously disclosed, in connection with our government investigations, five putative stockholder derivative actions were filed between October and November 2007. Four of these actions were asserted against directors Kevin Hickey, Alif Hourani, Christian Michalik and Neal Moszkowski, our current directors who were directors prior to 2007, and against former directors Regina Herzlinger and Ruben King-Shaw, and former director and officer Todd Farha. These actions also name us as a nominal defendant. Two of these actions were filed in the United States District Court for the Middle District of Florida (the "Federal Court") and two actions were filed in the Circuit Court for Hillsborough County, Florida (the "State Court"). The fifth action, filed in the Federal Court, asserts claims against directors Robert Graham, Kevin Hickey, Alif Hourani, Christian Michalik and Neal Moszkowski, our current directors who were directors at the time the action was filed, and against former directors Regina Herzlinger and Ruben King-Shaw, former director and officer Todd Farha, and former officers Paul Behrens and Thaddeus Bereday. A sixth derivative action was filed in January 2008 in the Federal Court and asserted claims against all of these defendants except Robert Graham. All six of these actions contend, among other things, that the defendants allegedly allowed or caused us to misrepresent our reported financial results, in amounts unspecified in the pleadings, and seek damages and equitable relief for, among other things, the defendants' supposed breach of fiduciary duty, waste and unjust enrichment. In April 2009, upon the recommendation of the Nominating and Corporate Governance Committee of the Board, the Board formed a Special Litigation Committee, comprised of a newly-appointed independent director, to investigate the facts and circumstances underlying the claims asserted in the derivative cases and to take such action with respect to these claims as the Special Litigation Committee determines to be in our best interests. In November 2009, the Special Litigation Committee filed a report with the United States District Court for the Middle District of Florida determining, among other things, that we should pursue an action against three of our former officers. In December 2009, the Special Litigation Committee filed a motion to dismiss the claims against the director defendants and to realign us as a plaintiff for purposes of pursuing claims against former officers Messrs. Farha, Behrens and Bereday. In March 2010, a Stipulation of Partial Settlement ("Stipulation I") was filed in the Federal Court. Under the terms of Stipulation I, the plaintiffs in the federal action have agreed that the Special Litigation Committee's motion to dismiss the director defendants and to realign us as a plaintiff should be granted in its entirety. The plaintiffs in the consolidated federal putative shareholder derivative actions also have agreed to dismiss their claims against Messrs. Farha, Behrens and Bereday. In turn, we have agreed to pay or cause to be paid to plaintiffs' counsel in the federal action attorneys' fees in the amount of \$1,688. This amount has been included in the Other accrued expenses and liabilities line item in our Condensed Consolidated Balance Sheet as of March 31, 2010. In April 2010, the Federal Court entered an order preliminarily approving Stipulation I and directing us to provide notice to our shareholders. The Federal Court also scheduled a hearing for final approval in July 2010. At such hearing, the Federal Court will hear any objections raised, including objections raised by Messrs. Farha, Behrens and Bereday. In April 2010, a second Stipulation of Partial Settlement ("Stipulation II") was filed in the State Court. Under the terms of Stipulation II, the plaintiffs in the state action have agreed that the Special Litigation Committee's motion to dismiss the director defendants and to realign us as a plaintiff should be granted in its entirety. In turn, we have agreed to pay or cause to be paid to plaintiffs' counsel in the state action attorneys' fees in the amount of \$563. This amount has also been included in the Other accrued expenses and liabilities line item in our Condensed Consolidated Balance Sheet as of March 31, 2010. While filed with the State Court, Stipulation II still must be approved by the State Court. At this time, therefore, we cannot predict the probable outcome of these matters.

### ***Other Lawsuits and Claims***

Separate and apart from the legal matters described above, we are also involved in other legal actions that are in the normal course of our business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We currently believe that none of these actions, when finally concluded and determined, will have a material adverse effect on our financial position, results of operations or cash flows.

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

### Forward Looking Statements

This Quarterly Report on Form 10-Q for the three months ended March 31, 2010 ("2010 Form 10-Q") may include "forward-looking statements" within the meaning of Section 21E of the Securities Act of 1934, as amended, including, in particular, estimates, projections, guidance or outlook. Generally the words "believe," "expect," "anticipate," "may," "intend," "estimate," "anticipate," "plan," "project," "should" and similar expressions, identify forward-looking statements, which generally are not historical in nature. These statements may contain information about financial prospects, economic conditions and trends that involve risks and uncertainties. Please refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2009 ("2009 Form 10-K"), and to Part II, Item 1A - Risk Factors, in this 2010 Form 10-Q, for a discussion of certain risk factors which could materially affect our business, financial condition, cash flows, or results of operations. If any of those risks, or other risks not presently known to us or that we currently believe to not be significant, do materialize or develop into actual events, our business, financial condition, results of operations or prospects could be materially adversely affected. Given these risks and uncertainties, we can give no assurances that any results or events projected or contemplated by our forward-looking statements will in fact occur and we caution you not to place undue reliance on these statements. We caution you that we do not undertake any obligation to update forward-looking statements made by us.

### Overview

#### *Executive Summary*

We provide managed care services exclusively to government-sponsored health care programs, serving approximately 2.2 million members nation-wide. We believe that our broad range of experience and exclusive government focus allows us to efficiently and effectively serve our members and providers, while managing our ongoing operations. Our strategic priorities for 2010 include improving health care quality and access for our members, ensuring a competitive cost position and committing to prudent and profitable growth. We continue to work closely with providers and government clients to further enhance health care delivery; improving the quality of, and enhancing access to, government health care services for our members. Our cost management initiatives are concentrated on aligning our expense structure with our current revenue base through process improvement and other initiatives; focusing on ensuring a competitive cost position in terms of both administrative and medical expenses. We are also focused on programs that help governments provide quality care within their fiscal constraints and present us with long-term opportunities for prudent and profitable growth.

#### *General Economic and Political Environment*

The current economic and political environment is affecting our business in a number of ways, as more fully described throughout this 2010 Form 10-Q.

#### *Premium Rates and Payments*

The states in which we operate continue to experience fiscal challenges which have led to budget cuts and reductions in Medicaid premiums in certain states or rate increases that are below medical cost trends. In particular, we continue to experience pressure on rates in Florida and Georgia, two states from which we derive a substantial portion of our revenue. In addition, although premiums are contractually payable to us before or during the month in which we are obligated to provide services to our members, we have experienced delays in premium payments from certain states. Given the budget shortfalls in many states with which we contract, additional payment delays may occur in the future. In addition to these Medicaid challenges, the Centers for Medicare & Medicaid Services ("CMS") implemented 2010 Medicare Advantage ("MA") payment rates that are at or slightly below 2009 rates.

#### *Health Care Reform*

In late March 2010, President Obama signed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "2010 Acts"). We believe these laws will bring about significant changes to the American health care system. While these measures are intended to expand the number of U.S. citizens covered by health insurance and make other coverage, delivery, and payment changes to the current health care system, the costs of implementing the 2010 Acts will be financed, in part, by future reductions in the payments made to Medicare providers.

Having passed new health legislation, the federal government now faces the task of implementing the 2010 Acts throughout the system. We are reviewing the newly-enacted legislation and its potential effects on MA payments. We believe that any revisions to the existing system may put pressure on operating results, decrease member benefits, and/or increase member premiums.

The health reforms in the 2010 Acts present several challenges as well as opportunities for our Medicaid business. We anticipate that the reforms could significantly increase the number of citizens who are eligible to enroll in our Medicaid products. However, state budgets continue to be strained due to economic conditions and uncertain levels of federal financing for current populations. As a result, the effects of any potential future expansions are uncertain, making it difficult to determine whether the 2010 Acts will have a positive or negative impact on our Medicaid business.

## ***Business and Financial Outlook***

### *Business Trends*

Our revenues and medical benefits expenses for fiscal year 2010 will be lower than in prior periods due to our exit on December 31, 2009 from our MA private fee-for-service (“PFFS”) product and our exit from Medicaid programs in certain Florida counties during 2009. Premium revenue in our PFFS product represented approximately 40.9% of our MA reportable operating segment revenue and 16.5% of our consolidated premium revenue for the 2009 fiscal year. We anticipate that the withdrawal from the PFFS product may provide approximately \$40.0 million to \$60.0 million of excess capital in the insurance companies that underwrite this line of business, which we may be able to distribute to our unregulated subsidiaries through dividends. However, we currently believe we will not have the benefit of these dividends prior to 2011, if at all. Any dividend of surplus capital of our applicable insurance subsidiaries, including the timing and amount of any dividend, would be subject to a variety of factors, which could materially change the aforementioned timing and amount. Those factors include the ultimate financial performance of the PFFS product as well as the financial performance of other lines of business that operate in those insurance subsidiaries, approval from regulatory agencies and potential changes in regulatory capital requirements. For example, our current estimate of \$40.0 million to \$60.0 million has declined from previous estimates, because the financial performance of these insurance subsidiaries worsened during 2009.

During 2009, CMS imposed a marketing sanction against us that prohibited us from the marketing of, and enrollment into, all lines of our Medicare business from March until the sanction was released in November. As a result of the sanction, we were not eligible to receive auto-assignments of low-income subsidy (“LIS”), dual-eligible beneficiaries into our prescription drug plans (“PDP”), for January 2010 enrollment. We received auto-assignments of such members in subsequent months, although such assignments were at levels well below the level we typically experience in the month of January.

As of March 31, 2010, we serve members in our PDP programs in 49 states and the District of Columbia, as we exited the PDP program in Wisconsin at the end of 2009. Our auto-assigned PDP membership in Wisconsin was re-assigned to other plans. For 2010, we are below the CMS benchmarks in 19 regions, including the following eight new regions: Arizona, Central New England (Connecticut, Massachusetts, Rhode Island and Vermont), Louisiana, Mississippi, Missouri, New York, Oklahoma and Virginia.

### *Financial Impact of Government Investigations and Litigation*

As previously disclosed, pursuant to our consent to the entry of a final judgment against us in the United States District Court for the Middle District of Florida to resolve the previously disclosed informal investigation conducted by the United States Securities and Exchange Commission (the “SEC”), we agreed to pay in four installments, a civil penalty in the aggregate amount of \$10.0 million and disgorgement in the amount of one dollar plus post-judgment interest, of which the fourth installment was paid in May 2010. As previously disclosed, we remain engaged in resolution discussions as to matters under review with U.S. Department of Justice’s Civil Division (the “Civil Division”) and the U.S. Department of Health and Human Services’ Office of Inspector General (the “OIG”). Those discussions are ongoing and no final resolution has been reached. Management has accrued a liability of approximately \$60.0 million, discounted and recorded at its fair value of approximately \$56.4 million, for the resolution of these matters. We anticipate any settlement amounts would be payable in installments over a period of four to five years. The actual outcome of these matters may differ materially from the Company’s judgment.

## *Investigation Related Costs*

We have expended significant financial resources in connection with the investigations and related matters. Since the inception of these investigations through March 31, 2010, we have incurred a total of approximately \$169.7 million for administrative expenses associated with, or consequential to, these governmental and Company investigations for legal fees, accounting fees, consulting fees, employee recruitment and retention costs and other similar expenses. Approximately \$21.1 million, \$103.0 million, \$44.3 million and \$1.3 million of these investigation related costs were incurred in 2007, 2008, 2009 and the first three months of 2010, respectively. We expect to continue incurring additional costs in connection with the governmental and Company investigations and compliance with the DPA and related matters during its term. Although investigation related costs have gradually declined overall, we can provide no assurance that such costs will not be significant or increase in the future.

## **Basis of Presentation**

### *Segments*

Reportable operating segments are defined as components of an enterprise for which discrete financial information is available and evaluated on a regular basis by the chief operating decision-maker to determine how resources should be allocated to an individual segment and to assess performance of those segments. Previously, we reported two operating segments: Medicaid and Medicare, which coincide with our two main business lines. During the first quarter of 2010, we reassessed our segment reporting practices and made revisions to reflect our current method of managing performance and determining resource allocation, which includes reviewing the results of our PDP operations separately from other Medicare products. Accordingly, we now have three reportable segments within our two main business lines: Medicaid, MA and PDP. The PFFS product that we exited December 31, 2009 is reported within the MA segment. The prior periods have been revised to reflect this segment presentation.

We use three measures to assess the performance of our reportable business segments; premium revenue, medical benefits ratio (“MBR”) and gross margin. Our MBR represents the ratio of our medical benefits expense to the premiums we receive. Our gross margin is defined as our premium revenue less our medical benefits expense.

Our profitability depends in large part on our ability to, among other things, effectively price our health and prescription drug plans; manage medical benefits expense, including reserve estimates and pharmacy costs; contract with health care providers; and attract and retain members. In addition, factors such as regulation, competition and general economic conditions affect our operations and profitability. The effect of escalating health care costs, as well as any changes in our ability to negotiate competitive rates with our providers may impose further risks to our profitability and may have a material impact on our business, financial condition and results of operations.

### *Medicaid*

Medicaid was established to provide medical assistance to low-income and disabled persons. It is state operated and implemented, although it is funded and regulated by both the state and federal governments. Our Medicaid segment includes plans for beneficiaries of the Temporary Assistance for Needy Families (“TANF”) programs, Supplemental Security Income (“SSI”) programs, Aged Blind and Disabled (“ABD”) programs, Children’s Health Insurance Programs (“CHIP”) and Family Health Plus (“FHP”) programs. TANF generally provides assistance to low-income families with children and SSI generally provides assistance to low-income aged, blind or disabled individuals. Our Medicaid segment also includes other programs that are not part of the Medicaid program, such as CHIP and FHP, for qualifying families who are not eligible for Medicaid because they exceed the applicable income thresholds.

The Medicaid programs and services we offer to our members vary by state and county and are designed to serve our various constituencies effectively in the communities we serve. Although our Medicaid contracts determine to a large extent the type and scope of health care services that we arrange for our members, in certain markets we customize our benefits in ways that we believe make our products more attractive. Our Medicaid plans provide our members with access to a broad spectrum of medical benefits from many facets of primary care and preventive programs to full hospitalization and tertiary care.

In general, members are required to use our network, except in cases of emergencies, transition of care or when network providers are unavailable to meet their medical needs, and generally must receive a referral from their PCPs in order to receive health care from specialists, such as orthopedic surgeons or neurologists. Members do not pay any premiums, deductibles or co-payments for most of our Medicaid plans.

### *Medicare Advantage*

Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons a variety of hospital, medical and prescription drug benefits. Our MA segment includes MA plans, which following the exit of our PFFS product on December 31, 2009, is comprised of coordinated care plans (“CCPs”). MA is Medicare’s managed care alternative to original Medicare fee-for-service (“Original Medicare”), which provides individuals standard Medicare benefits directly through CMS. CCPs are administered through health maintenance organizations (“HMOs”) and generally require members to seek health care services from a network of health care providers. In addition, we offer Medicare Part D coverage, which provides prescription drug benefits, as a component of our MA plans.

Through our MA plans, we also cover a wide spectrum of medical services. We provide additional benefits not covered by Original Medicare, such as vision, dental and hearing services. Through these enhanced benefits, the out-of-pocket expenses incurred by our members are reduced, which allows our members to better manage their health care costs.

Most of our MA plans require members to pay a co-payment, which varies depending on the services and level of benefits provided. Typically, members of our MA CCPs are required to use our network of providers except in cases such as emergencies, transition of care or when specialty providers are unavailable to meet a member’s medical needs. MA CCP members may see an out-of-network specialist if they receive a referral from their PCP and may pay incremental cost-sharing. In most of our markets, we also offer special needs plans to individuals who are dually eligible for Medicare and Medicaid. These plans, commonly called D-SNPs, are designed to provide specialized care and support for beneficiaries who are dually eligible for both Medicare and Medicaid. We believe that our D-SNPs are attractive to these beneficiaries due to the enhanced benefit offerings and clinical support programs.

### *PDP*

We offer stand-alone Medicare Part D coverage to Medicare eligible beneficiaries in our PDP segment. The Medicare Part D prescription drug benefit is supported by risk-sharing with the federal government through risk corridors designed to limit the losses and gains of the drug plans and by reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for risk factor payments. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries. The Part D program offers national in-network prescription drug coverage that is subject to limitations in certain circumstances.

Depending on medical coverage type, a beneficiary has various options for accessing drug coverage. Beneficiaries enrolled in Original Medicare can either join a stand-alone PDP or forego Part D drug coverage. Beneficiaries enrolled in MA CCPs can join a plan with Part D coverage, select a separate Part D plan, or forego Part D coverage.

### **Gross Margin**

Our primary tools for measuring profitability are gross margin and MBR. Changes in gross margin and MBR from period to period result from, among other things, changes in Medicaid and Medicare funding, changes in the mix of Medicaid and Medicare membership, our ability to manage medical costs and changes in accounting estimates related to claims incurred but not reported (“IBNR”). Estimation of medical benefits payable is our most significant critical accounting estimate. See “Critical Accounting Estimates” below. We use gross margin and MBRs both to monitor our management of medical benefits expense and to make various business decisions, including what health care plans to offer, what geographic areas to enter or exit and which health care providers to select. Although gross margin and MBRs play an important role in our business strategy, we may be willing to enter new geographical markets and/or enter into provider arrangements that might produce a less favorable gross margin and MBR if those arrangements, such as capitation or risk-sharing, would likely lower our exposure to variability in medical costs and for other reasons.

## Critical Accounting Estimates

In the ordinary course of business, we make a number of estimates and assumptions relating to the reporting of our results of operations and financial condition in conformity with accounting principles generally accepted in the United States. We base our estimates on historical experience and on various other assumptions that we believe to be reasonable under the circumstances. Actual results could differ significantly from those estimates under different assumptions and conditions. We believe that our accounting policies relating to revenue recognition, medical benefits expense and medical benefits payable, and goodwill and intangible assets, are those that are most important to the portrayal of our financial condition and results and require management's most difficult, subjective and complex judgments, often as a result of the need to make estimates about the effect of matters that are inherently uncertain. We have not changed these policies from those previously disclosed in our 2009 Form 10-K. Our critical accounting estimates relating to medical benefits payable and medical benefits expense, and the quantification of the sensitivity of financial results to reasonably possible changes in the underlying assumptions used in such estimation as of March 31, 2010, is discussed below. Additionally, we continually assess our estimates related to goodwill and intangible assets, which is discussed in further detail below. There were no other significant changes to the critical accounting estimates as disclosed in our 2009 Form 10-K.

### *Estimating Medical Benefits Payable and Medical Benefits Expense*

The cost of medical benefits is recognized in the period in which services are provided and includes an estimate of the cost of IBNR medical benefits. Medical benefits expense has two main components: direct medical expenses and medically-related administrative costs. Direct medical expenses include amounts paid or payable to hospitals, physicians and providers of ancillary services, such as laboratory and pharmacy. Medically-related administrative costs include items such as case and disease management, utilization review services, quality assurance and on-call nurses. Medical benefits payable on our Condensed Consolidated Balance Sheets represents amounts for claims fully adjudicated awaiting payment disbursement of \$73.1 million and \$53.0 million, and estimates for IBNR claims of \$633.7 million and \$749.5 million, as of March 31, 2010 and December 31, 2009, respectively.

The medical benefits payable estimate has been and continues to be our most significant estimate included in our financial statements. We historically have used and continue to use a consistent methodology for estimating our medical benefits expense and medical benefits payable. Our policy is to record management's best estimate of medical benefits payable based on the experience and information available to us at the time. This estimate is determined utilizing standard actuarial methodologies based upon historical experience and key assumptions consisting of trend factors and completion factors using an assumption of moderately adverse conditions, which vary by business segment. These standard actuarial methodologies include using, among other factors, contractual requirements, historic utilization trends, the interval between the date services are rendered and the date claims are paid, denied claims activity, disputed claims activity, benefits changes, expected health care cost inflation, seasonality patterns, maturity of lines of business and changes in membership.

The factors and assumptions described above that are used to develop our estimate of medical benefits expense and medical benefits payable inherently are subject to greater variability when there is more limited experience or information available to us. The ultimate claims payment amounts, patterns and trends for new products and geographic areas cannot be precisely predicted at their onset, since we, the providers and the members do not have experience in these products or geographic areas. Standard accepted actuarial methodologies, discussed above, would allow for this inherent variability, which could result in larger differences between the originally estimated medical benefits payable and the actual claims amounts paid. Conversely, during periods where our products and geographies are more stable and mature, we have more reliable claims payment patterns and trend experience. With more reliable data, we should be able to more closely estimate the ultimate claims payment amounts; therefore, we may experience smaller differences between our original estimate of medical benefits payable and the actual claim amounts paid.

In developing our estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For the more recent months, which constitute the majority of the amount of the medical benefits payable, we estimate claims incurred by applying observed trend factors to the fixed fee per-member per-month ("PMPM") costs for prior months, which costs have been estimated using completion factors, in order to estimate the PMPM costs for the most recent months. We validate our estimates of the most recent PMPM costs by comparing the most recent months' utilization levels to the utilization levels in prior months and actuarial techniques that incorporate a historical analysis of claim payments, including trends in cost of care provided and timeliness of submission and processing of claims.

Many aspects of the managed care business are not predictable. These aspects include the incidences of illness or disease state (such as cardiac heart failure cases, cases of upper respiratory illness, the length and severity of the flu season, diabetes, the number of full-term versus premature births and the number of neonatal intensive care babies). Therefore, we must continually monitor our historical experience in determining our trend assumptions to reflect the ever-changing mix, needs and growth of our membership. Among the factors considered by management are changes in the level of benefits provided to members, seasonal variations in utilization, identified industry trends and changes in provider reimbursement arrangements, including changes in the percentage of reimbursements made on a capitation as opposed to a fee-for-service basis. These considerations are reflected in the trends in our medical benefits expense. Other external factors such as government-mandated benefits or other regulatory changes, catastrophes and epidemics may impact medical cost trends. Other internal factors such as system conversions and claims processing interruptions may impact our ability to accurately predict estimates of historical completion factors or medical cost trends. Medical cost trends potentially are more volatile than other segments of the economy. Management uses considerable judgment in determining medical benefits expense trends and other actuarial model inputs. We believe that the amount of medical benefits payable as of March 31, 2010 is adequate to cover our ultimate liability for unpaid claims as of that date; however, actual payments may differ from established estimates. If the completion factors we used in estimating our IBNR for the most recent three months at March 31, 2010 were decreased by 1%, our net income would decrease by approximately \$18.2 million. If the completion factors were increased by 1%, our net income would increase by approximately \$17.7 million.

We consistently recognize the actuarial best estimate of the ultimate medical benefits payable within a level of confidence, as required by actuarial standards of practice, which require that the medical benefits payable be adequate under moderately adverse conditions. As we establish the liability for each period, we ensure that our assumptions appropriately consider moderately adverse conditions. When a portion of the development related to the immediately preceding period incurred claims is offset by an increase determined appropriate to address moderately adverse conditions for the current period incurred claims, we do not consider that offset amount as having any impact on net income during the period.

Also included in medical benefits payable are estimates for provider settlements due to clarification of contract terms, out-of-network reimbursement, claims payment differences as well as amounts due to contracted providers under risk-sharing arrangements. We record reserves for estimated referral claims related to health care providers under contract with us who are financially troubled or insolvent and who may not be able to honor their obligations for the costs of medical services provided by other providers. In these instances, we may be required to honor these obligations for legal or business reasons. Based on our current assessment of providers under contract with us, such losses have not been and are not expected to be significant.

Changes in medical benefits payable estimates are primarily the result of obtaining more complete claims information and medical expense trend data over time. Volatility in members' needs for medical services, provider claims submissions and our payment processes result in identifiable patterns emerging several months after the causes of deviations from assumed trends occur. Since our estimates are based upon PMPM claims experience, changes cannot typically be explained by any single factor, but are the result of a number of interrelated variables, all influencing the resulting experienced medical cost trend. Differences in our financial statements between actual experience and estimates used to establish the liability, which we refer to as prior period developments, are recorded in the period when such differences become known, and have the effect of increasing or decreasing the reported medical benefits expense and resulting MBR in such periods.

Medical benefits expense was impacted by approximately \$4.6 million and \$30.0 million of net favorable development related to prior years during the three months ended March 31, 2010 and 2009, respectively. The prior period developments in the 2009 period were primarily attributable to favorable variances between actual experience and key assumptions relating to, among other items, trend factors and completion factors for claims incurred in prior years, and for the 2010 period, prior period developments were primarily related to the reduction of the provision for moderately adverse conditions resulting from the exit of the PFFS product on December 31, 2009. For all of our other business, the release of the provision for moderately adverse conditions was substantially offset by the provision for moderately adverse conditions established for claims incurred in the current year. Accordingly, the change in the amount of the incurred claims related to prior years in the Medical benefits payable does not directly correspond to an increase in net income recognized during the period.

#### *Goodwill and Intangible Assets*

We review goodwill and intangible assets for impairment at least annually, or more frequently if events or changes in circumstances occur that may affect the estimated useful life or the recoverability of the remaining balance of goodwill or intangible assets. Events or changes in circumstances would include significant changes in membership, state funding, medical contracts and provider networks. We evaluate the impairment of goodwill and intangible assets using both the income and market approach. In doing so, we must make

assumptions and estimates, such as the discount factor, in determining the estimated fair values. While we believe these assumptions and estimates are appropriate, other assumptions and estimates could be applied and might produce significantly different results. An impairment loss is recognized for goodwill and intangible assets if the carrying value of such assets exceeds its fair value. We select the second quarter of each year for our annual impairment test, which generally coincides with the finalization of state and federal contract negotiations and our initial budgeting process. We have assessed the book value of goodwill and other intangible assets and reviewed for any triggering events that may have occurred during the period and we determined that there were no indications of impairment as of March 31, 2010.

In addition, we have evaluated the intangible assets in connection with our PFFS exit on December 31, 2009, which primarily consisted of state licenses for the insurance companies. As we continue to use these company licenses for other lines of business and the licenses have a market value, we determined that these assets have not been impaired as of March 31, 2010.

## Results of Operations

### *For the Three-Month Period Ended March 31, 2010 Compared to the Three-Month Period Ended March 31, 2009*

#### *Summary of Financial Information:*

The following table sets forth condensed consolidated statements of income data, as well as other key data used in our results of operations discussion. These historical results are not necessarily indicative of results to be expected for any future period.

|  | <b>Three months ended March</b> |                  | <b>\$ Variance</b> | <b>% Variance</b> |
|--|---------------------------------|------------------|--------------------|-------------------|
|  | <b>2010</b>                     | <b>2009</b>      |                    |                   |
| <b>Consolidated Income Statement Data:</b> |                                 |                  |                    |                   |
| Revenues:                                  |                                 |                  |                    |                   |
| Premium                                    | \$ 1,353.5                      | \$ 1,791.9       | \$ (438.4)         | (24.5)%           |
| Investment and other income                | 2.5                             | 3.3              | (0.8)              | (24.2)%           |
| Total revenues                             | <u>1,356.0</u>                  | <u>1,795.2</u>   | <u>(439.2)</u>     | <u>(24.5)%</u>    |
| Expenses:                                  |                                 |                  |                    |                   |
| Medical benefits                           | 1,166.0                         | 1,553.0          | (387.0)            | (24.9)%           |
| Selling, general and administrative        | 173.3                           | 271.7            | (98.4)             | (36.2)%           |
| Depreciation and amortization              | 5.8                             | 5.7              | 0.1                | 1.8%              |
| Interest                                   | 0.0                             | 2.1              | (2.1)              | n/m               |
| Total expenses                             | <u>1,345.1</u>                  | <u>1,832.5</u>   | <u>(487.4)</u>     | <u>(26.6)%</u>    |
| Income (loss) before income taxes          | 10.9                            | (37.3)           | 48.2               | n/m               |
| Income tax expense (benefit)               | 4.5                             | (0.4)            | 4.9                | n/m               |
| Net income (loss)                          | <u>\$ 6.4</u>                   | <u>\$ (36.9)</u> | <u>\$ 43.3</u>     | <u>n/m</u>        |
| Net income (loss) per common share:        |                                 |                  |                    |                   |
| Basic                                      | \$ 0.15                         | \$ (0.89)        |                    |                   |
| Diluted                                    | \$ 0.15                         | \$ (0.89)        |                    |                   |
| Membership                                 | 2,186,000                       | 2,456,000        |                    |                   |
| Consolidated MBR                           | 86.1%                           | 86.7%            |                    |                   |

n/m Indicates percentage change between these years is considered either not measurable or not meaningful.

#### *Summary of Consolidated Financial Results:*

##### *Premium Revenue*

Premium revenues for the three months ended March 31, 2010 decreased \$438.4 million, or 24.5%, to \$1,353.5 million from \$1,791.9 million for the same period in the prior year. Total membership decreased by approximately 270,000 members from 2,456,000 as of March 31, 2009 to 2,186,000 as of March 31, 2010. The decrease is primarily attributable to the decline in membership in our PDP segment and the exit from our PFFS product, as discussed in the respective sections below.

### *Investment and Other Income*

Investment and other income for the three months ended March 31, 2010 decreased \$0.8 million, or 24.2%, to \$2.5 million from \$3.3 million for the same period in the prior year. The decrease was primarily due to reduced market rates on lower average investment and cash balances.

### *Medical Benefits Expense*

Medical benefits expense for the three months ended March 31, 2010 decreased \$387.0 million, or 24.9%, to \$1,166.0 million from \$1,553.0 million for the same period in the prior year. Our MBR was 86.1% for the three months ended March 31, 2010 compared to 86.7% for the same period in the prior year. The decrease in MBR was primarily due to the exit from our PFFS product, which had a higher MBR than our other products, and better performance of the PDP product in 2010. MBR was favorably impacted by 0.3% during the three months ended March 31, 2010 and 1.7% for the same period in the prior year due to the adjustment of previously established medical benefits payable based on actual claim submissions and other estimate changes as well as the reduction of the provision for moderately adverse conditions related to the exit from the PFFS product on December 31, 2009.

### *Selling, General and Administrative Expense*

Selling, general and administrative (“SG&A”) expense for the three months ended March 31, 2010 decreased \$98.4 million, or 36.2%, to \$173.3 million from \$271.7 million for the same period in the prior year. Our SG&A expense to revenue ratio (“SG&A ratio”) was 12.8% for the three months ended March 31, 2010 compared to 15.1% for the same period in the prior year. The lower SG&A ratio is primarily the result of recording a \$44.8 million accrual during the three month period ended March 31, 2009 in connection with the resolution of investigation-related matters that did not recur in 2010 as well as decreased legal, professional and retention expenses during the three months ended March 31, 2010, consequential to the governmental and Company investigations.

### *Income Tax Expense (Benefit)*

Income tax expense for the three months ended March 31, 2010 was \$4.5 million compared to \$0.4 million of income tax benefit for the same period in the prior year, with an effective tax rate of 41.0% and 0.9% at March 31, 2010 and 2009, respectively. The higher effective tax rate for the three months ended March 31, 2010 compared to the statutory rate is primarily attributable to certain non-deductible executive compensation costs. The lower effective tax rate for the three months ended March 31, 2009 was attributable to non-deductible SG&A expenses associated with, or consequential to, the governmental and Company investigations in the amount of \$44.8 million that resulted in a pre-tax book loss. These expenses did not recur during the three months ended March 31, 2010.

### *Net Income (Loss)*

Net income for the three months ended March 31, 2010 was \$6.4 million, compared to a \$36.9 million net loss for the same period in the prior year. The increase in net income is primarily due to reduced SG&A costs as well as a period-over-period decline in overall MBR, partially offset by the loss of gross margin from the withdrawal of our PFFS product as well as decreased premium revenue from our MA CCPs and PDPs.

### ***Reconciling Segment Results:***

The following table reconciles our reportable segment results with our income (loss) before income taxes, as reported under accounting principles generally accepted in the United States of America (“GAAP”).

| Reconciling Segment Results Data: | Three months ended March |                  |
|-----------------------------------|--------------------------|------------------|
|                                   | 2010                     | 2009             |
| Gross Margin:                     |                          |                  |
| Medicaid                          | \$ 107.3                 | \$ 119.4         |
| Medicare Advantage                | 74.9                     | 121.4            |
| PDP                               | 5.3                      | (1.9)            |
| Total gross margin                | <u>187.5</u>             | <u>238.9</u>     |
| Investment and other income       | 2.5                      | 3.3              |
| Other expenses                    | <u>(179.1)</u>           | <u>(279.5)</u>   |
| Income (loss) before income taxes | <u>\$ 10.9</u>           | <u>\$ (37.3)</u> |

**Medicaid Segment Results:**

|                                | <b>Three months ended March<br/>31,</b> |                  |
|--------------------------------|---|------------------|
|                                | <b>2010</b>                             | <b>2009</b>      |
| Medicaid Segment Results Data: |   |                  |
| Premium revenue                | \$ 809.1                                | \$ 809.2         |
| Medical benefits expense       | 701.8                                   | 689.8            |
| Gross margin                   | <u>\$ 107.3</u>                         | <u>\$ 119.4</u>  |
| Medicaid Membership:           |   |                  |
| TANF                           | 1,076,000                               | 1,080,000        |
| S-CHIP                         | 166,000                                 | 164,000          |
| SSI and ABD                    | 78,000                                  | 92,000           |
| FHP                            | <u>12,000</u>                           | <u>19,000</u>    |
|                                | <u>1,332,000</u>                        | <u>1,355,000</u> |
| Medicaid MBR                   | 86.7%                                   | 85.2%            |

Medicaid premium revenue for the three months ended March 31, 2010 was relatively flat compared to same period in the prior year. Membership decreased by approximately 23,000 members to 1,332,000 as of March 31, 2010, from 1,355,000 as of March 31, 2009. The decline in premium revenue from lower membership was attributed primarily to the decline in membership in Florida, partially offset by membership growth in Georgia and the inclusion of three full months of Hawaii ABD operations in 2010 compared to only two months in the prior year, as the program commenced in February 2009. Medicaid medical benefits expense increased \$12.0 million for the three months ended March 31, 2010 due to the impact of prior period reserve development in 2009, partially offset by an improvement in MBR. Medicaid MBR was impacted by 3.2% for favorable prior-period reserve development during the three months ended March 31, 2009.

**Medicare Advantage Segment Results:**

|  | <b>Three months ended March<br/>31,</b> |                 |
|--|---|-----------------|
|  | <b>2010</b>                             | <b>2009</b>     |
| Medicare Advantage Segment Results Data: |   |                 |
| Premium revenue                          | \$ 351.1                                | \$ 733.1        |
| Medical benefits expense                 | 276.2                                   | 611.7           |
| Gross margin                             | <u>\$ 74.9</u>                          | <u>\$ 121.4</u> |
| Medicare Advantage Membership            | 118,000                                 | 270,000         |
| Medicare Advantage MBR                   | 78.7%                                   | 83.4%           |

Our MA segment includes results from the PFFS product that we exited on December 31, 2009. MA premium revenue decreased by \$382.0 million for the three months ended March 31, 2010 when compared to the same period in the prior year, with the decrease being primarily attributable to the PFFS withdrawal and reduced membership due to our being unable to enroll new members during the 2009 CMS marketing sanction. Correspondingly, MA gross margin decreased by \$46.5 million for the three months ended March 31, 2010 compared to the same period in the prior year. The decrease in the MA MBR was primarily related to the withdrawal of PFFS plans, which operated at an MBR above the segment average and, to a lesser extent, prior period favorable reserve development related to the PFFS product. The MA segment membership decreased by approximately 152,000 members to 118,000 members as of March 31, 2010 from 270,000 members as of March 31, 2009. The decline in MA segment membership was caused by the PFFS withdrawal and the 2009 CMS marketing sanction.

### ***PDP Segment Results:***

|                           | <b>Three months ended March<br/>31,</b> |                 |
|---------------------------|---|-----------------|
|                           | <b>2010</b>                             | <b>2009</b>     |
| PDP Segment Results Data: |   |                 |
| Premium revenue           | \$ 193.3                                | \$ 249.6        |
| Medical benefits expense  | 188.0                                   | 251.5           |
| Gross margin              | <u>\$ 5.3</u>                           | <u>\$ (1.9)</u> |
| <br>                      |   |                 |
| PDP Membership            | 736,000                                 | 831,000         |
| <br>                      |   |                 |
| PDP MBR                   | 97.2%                                   | 100.7%          |

PDP premium revenue for the three months ended March 31, 2010 decreased \$56.3 million to \$193.3 million from \$249.6 million for the same period in the prior year due primarily to a decrease in membership. Membership within the PDP segment as of March 31, 2010 decreased by approximately 95,000 members compared to March 31, 2009. As a result of the CMS sanction, we were not eligible to receive auto-assignments of LIS dual-eligible beneficiaries into our PDP program for January 2010 enrollment, which impacted our membership. We received auto-assignments of such members in subsequent months, but the assignments were at levels well below what we would typically experience in the month of January. In addition, we exited the PDP program in Wisconsin at the end of 2009. PDP MBR for the three months ended March 31, 2010 was 97.2% compared to 100.7% for the same period in the prior year. PDP medical benefits expense for the three months ended March 31, 2010 decreased \$63.5 million to \$188.0 million, from \$251.5 million for the same period in the prior year. PDP gross margin for the three months ended March 31, 2010 increased \$7.2 million to \$5.3 million from \$(1.9) million for the same period in the prior year. The decrease in PDP MBR was the result of better overall performance on the Part D product.

### **Liquidity and Capital Resources**

#### ***Overview***

Each of our existing and anticipated sources of cash is impacted by operational and financial risks that influence the overall amount of cash generated and the capital available to us. For a further discussion of risks that can affect our liquidity, see "Risk Factors" in Part 1 – Item 1A included in our 2009 Form 10-K.

#### ***Cash Positions***

As of March 31, 2010, our consolidated cash and cash equivalents were approximately \$1,027.3 million, our consolidated investments were approximately \$102.4 million, our unregulated cash was approximately \$118.3 million and our unregulated investments were approximately \$2.7 million. As of December 31, 2009, our consolidated cash and cash equivalents were approximately \$1,158.1 million, our consolidated investments were approximately \$114.4 million, our unregulated cash was approximately \$117.6 million and our unregulated investments were approximately \$2.8 million.

We currently believe that we will be able to meet our known near-term monetary obligations and maintain sufficient liquidity to operate our business. However, one or more of our regulators could require one or more of our subsidiaries to maintain minimum levels of statutory net worth in excess of the amount required under the applicable state laws if the regulators were to determine that such a requirement were in the interest of our members. Further, there may be other potential adverse developments that could impede our ability to meet our obligations.

### *Initiatives to Increase Our Unregulated Cash*

We are pursuing alternatives to raise additional unregulated cash. Some of these initiatives include, but are not limited to, consideration of obtaining dividends from certain of our regulated subsidiaries to the extent that we are able to access any available excess capital and accessing the credit markets. However, we cannot provide any assurances that we will obtain applicable state regulatory approvals for dividends to our non-regulated subsidiaries by our regulated subsidiaries. In addition to dividends, our strategies include accessing the public and private debt and equity markets and potentially selling assets.

Our ability to obtain financing has been and continues to be materially and negatively affected by a number of factors. Although credit markets are currently experiencing some improvement as compared to 2009, market volatility and general adverse economic conditions have caused the cost of prospective debt financings to increase considerably. These circumstances have made terms for certain financing arrangements unattractive, and in some cases have resulted in the unavailability of financing. We also believe the uncertainty created by the ongoing state and federal investigations is adversely affecting our ability to obtain financing. In light of the current and evolving credit markets and the uncertainty created by the ongoing investigations, we may not be able to obtain financing. Even if we are able to obtain financing under these circumstances, the cost to us likely will be high and the terms and conditions likely will be onerous.

### *Auction Rate Securities*

As of March 31, 2010, all of our long-term investments were comprised of municipal note investments with an auction reset feature ("auction rate securities"). These auction rate securities are issued by various state and local municipal entities for the purpose of financing student loans, public projects and other activities; they carry an investment grade credit rating. Although auctions have failed in the past, we believe we will be able to liquidate these securities without significant loss, and we currently believe these securities are not impaired, primarily due to government guarantees or municipal bond insurance; however, it could take until the final maturity of the underlying securities to realize our investments' recorded value. In March 2010, one of our auction rate securities in the amount of \$6.3 million was called at par, at the option of the issuer. We currently have the ability and intent to hold our auction rate securities until maturity or full market stability is restored with respect to these securities.

### *Overview of Cash Flow Activities*

For the three-month periods ended March 31, 2010 and 2009 our cash flows are summarized as follows:

|  | <b>Three Months Ended March 31,</b> |             |
|--|-------------------------------------|-------------|
|  | <b>2010</b>                         | <b>2009</b> |
|  | <b>(In millions)</b>                |             |
| <b>Net cash used in operations</b>               | \$ (170.5)                          | \$ (105.8)  |
| <b>Net cash provided by investing activities</b> | 8.0                                 | 17.5        |
| <b>Net cash provided by financing activities</b> | 31.7                                | 41.0        |

*Cash used in Operations:* Because we generally receive premiums in advance of payments of claims for health care services, we maintain balances of cash and cash equivalents pending payment of claims. Our net income during the three months ended March 31, 2010 was \$6.4 million. Cash used in operations primarily consisted of a decrease in medical benefits payable of \$95.7 million and decrease in unearned premiums of \$90.4 million, partially offset by a decrease in premiums and other receivables of \$23.8 million.

*Cash provided by Investing Activities:* During the three-month period ended March 31, 2010, investing activities consisted primarily of the net proceeds from the sale and maturity of investments totaling approximately \$12.3 million, partially offset by the purchases of property and equipment totaling approximately \$4.2 million.

*Cash provided by Financing Activities:* Included in financing activities are funds held for the benefit of members, which increased approximately \$34.0 million as of March 31, 2010. These PDP member subsidies represent pass-through payments from government partners and are not accounted for in our results of operations since they represent payments to fund deductibles, co-payments and other member benefits for certain of our members.

### **Item 3. Quantitative and Qualitative Disclosures about Market Risk.**

As of March 31, 2010, we had cash and cash equivalents of \$1,027.3 million, investments classified as current assets of \$56.8 million, long-term investments of \$45.6 million and restricted investments on deposit for licensure of \$130.5 million. The short-term investments classified as current assets consist of highly liquid securities with maturities between three and twelve months and longer term bonds with floating interest rates that are considered available for sale. Long-term restricted assets consist of cash and cash equivalents deposited or pledged to state agencies in accordance with state rules and regulations. These restricted assets are classified as long term regardless of the contractual maturity date due to the long-term nature of the states' requirements. The restricted investments classified as long-term are subject to interest rate risk and will decrease in value if market rates increase. Because of their short-term pricing nature, however, we would not expect the value of these investments to decline significantly as a result of a sudden change in market interest rates. Assuming a hypothetical and immediate 1.0% increase in market interest rates at March 31, 2010 the fair value of our fixed income short-term investments would decrease by less than \$0.1 million. Similarly, a 1.0% decrease in market interest rates at March 31, 2010 would result in an increase of the fair value of our short-term investments of less than \$0.6 million.

### **Item 4. Controls and Procedures.**

#### *Evaluation of Disclosure Controls and Procedures*

Our management carried out an evaluation required by Rule 13a-15 under the Exchange Act, under the leadership and with the participation of our President and Chief Executive Officer ("CEO") and Chief Financial Officer ("CFO"), of the effectiveness of our disclosure controls and procedures as defined in Rule 13a-15 under the Exchange Act ("Disclosure Controls"). Based on the evaluation, our CEO and CFO concluded that our Disclosure Controls were effective as of the end of the period covered by this Quarterly Report.

#### *Changes in Internal Control Over Financial Reporting*

There has not been any change in our internal control over financial reporting (as defined in Rule 13a-15(f) of the Exchange Act) identified in connection with the evaluation required by Rule 13a-15(d) under the Exchange Act during the quarter ended March 31, 2010 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

## Part II – OTHER INFORMATION

### Item 1. Legal Proceedings.

Information relating to legal proceedings, including a description of the status of ongoing investigations, actions and lawsuits arising from, or consequential to, these investigations is discussed in our 2009 Form 10-K. Set forth below are the material developments that occurred since the filing date of our 2009 Form 10-K.

As previously disclosed, we remain engaged in resolution discussions as to matters under review with the U.S. Department of Justice's Civil Division (the "Civil Division") and the U.S. Department of Health and Human Services' Office of Inspector General (the "OIG"). In May 2010, as part of the ongoing resolution discussions with the Civil Division, we were provided a copy of the *qui tam* complaints, in response to our request, which otherwise remain under seal as required by 31 U.S.C. section 3730(b)(3).

In April 2010, the Lead Plaintiffs filed their motion for class certification in the previously reported putative class action litigation entitled *Eastwood Enterprises, L.L.C. v. Farha, et al. and Hutton v. WellCare Health Plans, Inc. et al.*, respectively, which were filed in the United States District Court for the Middle District of Florida against us, Todd Farha, our former chairman and chief executive officer, and Paul Behrens, our former senior vice president and chief financial officer.

In March 2010, a Stipulation of Partial Settlement ("Stipulation I") was filed in the United States District Court for the Middle District of Florida (the "Federal Court"), relating to the consolidated putative stockholder derivative actions pending in Federal court. Under the terms of Stipulation I, the plaintiffs in the federal actions have agreed that the Special Litigation Committee's motion to dismiss the director defendants and to realign us as a plaintiff should be granted in its entirety. The plaintiffs in the consolidated federal putative shareholder derivative actions also have agreed to dismiss their claims against Messrs. Farha, Behrens and Bereday. In turn, we have agreed to pay or cause to be paid to plaintiffs' counsel in the federal action attorneys' fees in the amount of approximately \$1.7 million. In April 2010, the Federal Court entered an order preliminarily approving Stipulation I and directing us to provide notice to our shareholders. The Federal Court also scheduled a hearing for final approval in July 2010. At such hearing, the Federal Court will hear any objections raised, including objections raised by Messrs. Farha, Behrens and Bereday. In April 2010, a second Stipulation of Partial Settlement ("Stipulation II") was filed in the Circuit Court for Hillsborough County, Florida (the "State Court"). Under the terms of Stipulation II, the plaintiffs in the state action have agreed that the Special Litigation Committee's motion to dismiss the director defendants and to realign us as a plaintiff should be granted in its entirety. In turn, we have agreed to pay or cause to be paid to plaintiffs' counsel in the state action attorneys' fees in the amount of approximately \$0.6 million. While filed with the State Court, Stipulation II still must be approved by the State Court. At this time, therefore, we cannot predict the probable outcome of these matters.

### Item 1A. Risk Factors.

Set forth below is a material update to the risk factors disclosed in "Part I – Item 1A – Risk Factors" of our 2009 Form 10-K.

#### **Recently enacted health legislation is expected to bring about significant reform to the American health care system; and present challenges for our business that could have a material adverse effect on our results of operations and cash flows.**

In late March 2010, President Obama signed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "2010 Acts"). We believe these laws will bring about significant changes to the American health care system. These laws are intended to expand the number of U.S. citizens covered by health insurance over time by increasing the eligibility thresholds for most state Medicaid programs and make other coverage, delivery, and payment changes to the current health care system. Health care reform is expected to trigger transformation and disruption across the industry. Although most major provisions become effective in 2014, some, such as changes to Medicare Advantage election periods, are effective sooner.

The costs of implementing the 2010 Acts will be financed, in part, by future reductions in the payments made to Medicare providers. Furthermore, the 2010 Acts contain other provisions that may adversely affect our profitability, including a phased reduction of Medicare Advantage rates, Medicare Advantage payments tied to quality scores, minimum loss ratios for Medicare Advantage effective in 2014 and imposition of an annual fee on the health insurance sector that will be allocated across the industry according to each company's respective market share compared to the overall industry, effective in 2014. Any of the aforementioned revisions to the existing system may adversely impact our results of operations and cash flows. Additionally, our efforts to implement these revisions may detract us from carrying out our strategic priorities and may burden our operational capacity and available capital, and could have an adverse effect on our business.

Currently, we anticipate that the 2010 Acts could significantly increase the number of citizens who are eligible to enroll in our Medicaid products. Accordingly, we will need to evaluate our capability to absorb the potential increase in demand from the newly-insured. Regardless, state budgets continue to be strained due to economic conditions and uncertain levels of federal financing for current populations. Additionally, many of the provisions of the 2010 Acts will be implemented through regulations that have yet to be adopted. As a result, the effects of any potential future expansions could result in lower payment rates, making it difficult to determine whether the 2010 Acts will have a positive or negative impact on our business.



## Item 2. Unregistered Sales of Equity Securities and Use of Proceeds.

### *Recent Sales of Unregistered Securities*

We did not sell any securities in the three months ended March 31, 2010 that were not registered under the Securities Act of 1933, as amended.

### *Issuer Purchases of Equity Securities*

We do not have a stock repurchase program. However, during the quarter ended March 31, 2010, certain of our employees were deemed to have surrendered shares of our common stock to satisfy their withholding tax obligations associated with the vesting of shares of restricted common stock. The following table summarizes these repurchases:

| <b>Period</b>                              | <b>Total Number<br/>of Shares<br/>Purchased(1)</b> | <b>Average<br/>Price Paid<br/>Per Share(1)</b> | <b>Total Number<br/>of Shares<br/>Purchased as<br/>Part of<br/>Publicly<br/>Announced<br/>Plans or<br/>Programs</b> | <b>Maximum<br/>Number of<br/>Shares that<br/>May Yet Be<br/>Purchased<br/>Under the<br/>Plans or<br/>Programs</b> |
|--|--|--|---|---|
| January 1, 2010 through January 31, 2010   | 10,858   | \$ 35.45(2)                                    | N/A   | N/A   |
| February 1, 2010 through February 28, 2010 | 451  | \$ 29.63(3)                                    | N/A   | N/A   |
| March 1, 2010 through March 31, 2010       | 8,323  | \$ 29.89(4)                                    | N/A   | N/A   |
| Total during quarter ended March 31, 2010  | 19,632   | \$ 30.25(5)                                    | N/A   | N/A   |

- (1) The number of shares purchased represent the number of shares of our common stock deemed surrendered by our employees to satisfy their withholding tax obligations due to the vesting of shares of restricted common stock. For the purposes of this table, we determined the average price paid per share based on the closing price of our common stock as of the date of the determination of the withholding tax amounts (i.e., the date that the shares of restricted stock vested). We do not currently have a stock repurchase program. We did not pay any cash consideration to repurchase these shares.
- (2) The weighted average price paid per share during the period was \$33.94.
- (3) The weighted average price paid per share during the period was \$28.79.
- (4) The weighted average price paid per share during the period was \$30.08.
- (5) The weighted average price paid per share during the period was \$31.99.

## Item 6. Exhibits.

Exhibits are incorporated herein by reference or are filed with this report as set forth in the Exhibit Index on page 28 hereof.

## SIGNATURES

Pursuant to the requirements of the Securities and Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized in Tampa, Florida on May 6, 2010.

WELLCARE HEALTH PLANS, INC.

By: /s/ Thomas L. Tran  
Thomas L. Tran  
Senior Vice President and Chief Financial Officer (Principal Financial Officer)

By: /s/ Maurice S. Hebert  
Maurice S. Hebert  
Chief Accounting Officer (Principal Accounting Officer)

Morningstar<sup>®</sup> Document Research<sup>SM</sup>

## **FORM 10-Q**

**WELLCARE HEALTH PLANS, INC. - WCG**

**Filed: August 09, 2010 (period: June 30, 2010)**

Quarterly report which provides a continuing view of a company's financial position

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**UNITED STATES**  
**SECURITIES AND EXCHANGE COMMISSION**  
Washington, D.C. 20549  
**FORM 10-Q**

(Mark One)

**QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**  
For the quarterly period ended **June 30, 2010**  
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: **001-32209**

**WELLCARE HEALTH PLANS, INC.**  
(Exact name of registrant as specified in its charter)

**Delaware**  
(State or other jurisdiction of  
incorporation or organization)

**47-0937650**  
(I.R.S. Employer  
Identification No.)

**8725 Henderson Road, Renaissance One**  
**Tampa, Florida**  
(Address of principal executive offices)

**33634**  
(Zip Code)

**(813) 290-6200**

(Registrant's telephone number, including area code)

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.

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 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 "smaller reporting company" in Rule 12b-2 of the Exchange Act

Large Accelerated Filer  Accelerated Filer  Non-Accelerated Filer   
Smaller Reporting Company  (Do not check if a 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

As of August 4, 2010 there were 42,497,604 shares of the registrant's common stock, par value \$.01 per share, outstanding.

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WELLCARE HEALTH PLANS, INC.

TABLE OF CONTENTS

|                                       | <u>Page</u>   |    |
|---------------------------------------|---|----|
| <b>Part I — FINANCIAL INFORMATION</b> |   |    |
| Item 1.                               | Financial Statements  |    |
|                                       | Condensed Consolidated Balance Sheets at June 30, 2010 (unaudited) and December 31, 2009                              | 3  |
|                                       | Condensed Consolidated Statements of Operations for the three and six months ended June 30, 2010 and 2009 (unaudited) | 4  |
|                                       | Condensed Consolidated Statements of Cash Flows for the six months ended June 30, 2010 and 2009 (unaudited)           | 5  |
|                                       | Notes to Condensed Consolidated Financial Statements  | 6  |
| Item 2.                               | Management's Discussion and Analysis of Financial Condition and Results of Operations                                 | 18 |
| Item 3.                               | Quantitative and Qualitative Disclosures About Market Risk  | 31 |
| Item 4.                               | Controls and Procedures   | 32 |
| <b>Part II — OTHER INFORMATION</b>    |   |    |
| Item 1.                               | Legal Proceedings   | 33 |
| Item 1A.                              | Risk Factors  | 34 |
| Item 2.                               | Unregistered Sales of Equity Securities and Use of Proceeds   | 35 |
| Item 5.                               | Other Information   | 36 |
| Item 6.                               | Exhibits  | 37 |
|                                       | Signatures  |    |

**Part I — FINANCIAL INFORMATION****Item 1. Financial Statements.**

**WELLCARE HEALTH PLANS, INC.**  
**CONDENSED CONSOLIDATED BALANCE SHEETS**  
(In thousands, except share data)

|   | <b>June 30,<br/>2010</b> | <b>December 31,<br/>2009</b> |
|---|--------------------------|------------------------------|
|   | (Unaudited)              |                              |
| <b>Assets</b>   |                          |                              |
| <b>Current Assets:</b>  |                          |                              |
| Cash and cash equivalents   | \$ 980,264               | \$ 1,158,131                 |
| Investments   | 45,018                   | 62,722                       |
| Premium and other receivables, net  | 316,359                  | 285,808                      |
| Funds receivable for the benefit of members   | 29,298                   | 77,851                       |
| Prepaid expenses and other current assets, net  | 106,226                  | 104,079                      |
| Deferred income tax asset   | 33,857                   | 28,874                       |
| Total current assets  | 1,511,022                | 1,717,465                    |
| Property, equipment and capitalized software, net   | 65,299                   | 61,785                       |
| Goodwill  | 111,131                  | 111,131                      |
| Other intangible assets, net  | 12,194                   | 12,961                       |
| Long-term investments   | 42,477                   | 51,710                       |
| Restricted investments  | 131,654                  | 130,550                      |
| Deferred income tax asset   | 81,544                   | 18,745                       |
| Other assets  | 10,480                   | 14,100                       |
| Total Assets  | \$ 1,965,801             | \$ 2,118,447                 |
| <b>Liabilities and Stockholders' Equity</b>   |                          |                              |
| <b>Current Liabilities:</b>   |                          |                              |
| Medical benefits payable  | \$ 660,149               | \$ 802,515                   |
| Unearned premiums   | 114                      | 90,496                       |
| Accounts payable  | 8,063                    | 5,270                        |
| Other accrued expenses and liabilities  | 152,304                  | 220,562                      |
| Current portion of amounts accrued related to investigation resolution  | 83,672                   | 18,192                       |
| Other payables to government partners   | 35,952                   | 38,147                       |
| Income taxes payable  | 8,204                    | 4,888                        |
| Total current liabilities   | 948,458                  | 1,180,070                    |
| Amounts accrued related to investigation resolution   | 244,284                  | 40,205                       |
| Other liabilities   | 17,175                   | 17,272                       |
| Total liabilities   | 1,209,917                | 1,237,547                    |
| Commitments and contingencies (See Note 6)  | —                        | —                            |
| <b>Stockholders' Equity:</b>  |                          |                              |
| Preferred stock, \$0.01 par value (20,000,000 authorized, no shares issued or outstanding)  | —                        | —                            |
| Common stock, \$0.01 par value (100,000,000 authorized, 42,427,502 and 42,361,207 shares issued and outstanding at June 30, 2010 and December 31, 2009, respectively) | 424                      | 424                          |
| Paid-in capital   | 421,490                  | 425,083                      |
| Retained earnings   | 336,059                  | 458,512                      |
| Accumulated other comprehensive loss  | (2,089)                  | (3,119)                      |
| Total stockholders' equity  | 755,884                  | 880,900                      |
| Total Liabilities and Stockholders' Equity  | \$ 1,965,801             | \$ 2,118,447                 |

*See notes to unaudited condensed consolidated financial statements.*

**WELLCARE HEALTH PLANS, INC.**  
**CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS**  
**(Unaudited, in thousands, except per share data)**

|   | Three Months Ended<br>June 30, |                  | Six Months Ended<br>June 30, |                  |
|---|--------------------------------|------------------|------------------------------|------------------|
|   | 2010                           | 2009             | 2010                         | 2009             |
| <b>Revenues:</b>  |                                |                  |                              |                  |
| Premium   | \$ 1,337,937                   | \$ 1,787,851     | \$ 2,691,395                 | \$ 3,579,778     |
| Investment and other income                             | 2,712                          | 3,427            | 5,207                        | 6,761            |
| Total revenues  | <u>1,340,649</u>               | <u>1,791,278</u> | <u>2,696,602</u>             | <u>3,586,539</u> |
| <b>Expenses:</b>  |                                |                  |                              |                  |
| Medical benefits  | 1,122,791                      | 1,504,019        | 2,288,763                    | 3,057,017        |
| Selling, general and administrative                     | 404,770                        | 215,082          | 578,107                      | 486,823          |
| Depreciation and amortization                           | 5,891                          | 5,957            | 11,647                       | 11,696           |
| Interest  | 33                             | 1,017            | 43                           | 3,083            |
| Total expenses  | <u>1,533,485</u>               | <u>1,726,075</u> | <u>2,878,560</u>             | <u>3,558,619</u> |
| (Loss) income before income taxes                       | (192,836)                      | 65,203           | (181,958)                    | 27,920           |
| Income tax (benefit) expense                            | (63,965)                       | 28,198           | (59,505)                     | 27,848           |
| Net (loss) income                                       | <u>\$ (128,871)</u>            | <u>\$ 37,005</u> | <u>\$ (122,453)</u>          | <u>\$ 72</u>     |
| <b>Net (loss) income per common share (see Note 1):</b> |                                |                  |                              |                  |
| Basic   | \$ (3.05)                      | \$ 0.89          | \$ (2.90)                    | \$ 0.00          |
| Diluted   | \$ (3.05)                      | \$ 0.88          | \$ (2.90)                    | \$ 0.00          |

*See notes to unaudited condensed consolidated financial statements.*

**WELLCARE HEALTH PLANS, INC.**  
**CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS**  
**(Unaudited, in thousands)**

|  | <b>Six Months Ended June 30,</b> |                   |
|--|----------------------------------|-------------------|
|  | <b>2010</b>                      | <b>2009</b>       |
| <b>Cash provided by (used in) operating activities:</b>                              |                                  |                   |
| Net (loss) income  | \$ (122,453)                     | \$ 72             |
| Adjustments to reconcile net (loss) income to net cash used in operating activities: |                                  |                   |
| Depreciation and amortization  | 11,647                           | 11,696            |
| Equity-based compensation expense  | 2,479                            | 19,242            |
| Deferred taxes, net  | (67,782)                         | (12,025)          |
| Changes in operating accounts:   |                                  |                   |
| Premium and other receivables, net   | (30,551)                         | (162,498)         |
| Other receivables from government partners, net                                      | -                                | (58,156)          |
| Prepaid expenses and other, net  | (2,147)                          | 14,204            |
| Medical benefits payable   | (142,366)                        | 92,181            |
| Unearned premiums  | (90,382)                         | (61,866)          |
| Accounts payable and other accrued expenses  | (43,703)                         | (78,175)          |
| Other payables to government partners  | (2,195)                          | 16,859            |
| Amounts accrued related to investigation resolution                                  | 246,621                          | 32,293            |
| Income taxes, net  | (455)                            | 36,875            |
| Other, net   | (3,327)                          | (698)             |
| Net cash used in operating activities  | <u>(244,614)</u>                 | <u>(149,996)</u>  |
| <b>Cash provided by (used in) investing activities:</b>                              |                                  |                   |
| Purchases of investments   | (2,049)                          | (19,066)          |
| Proceeds from sales and maturities of investments                                    | 30,603                           | 19,183            |
| Purchases of restricted investments  | (6,777)                          | (26,813)          |
| Proceeds from maturities of restricted investments                                   | 5,729                            | 47,743            |
| Additions to property, equipment and capitalized software, net                       | (6,872)                          | (8,198)           |
| Net cash provided by investing activities  | <u>20,634</u>                    | <u>12,849</u>     |
| <b>Cash provided by (used in) financing activities:</b>                              |                                  |                   |
| Proceeds from option exercises and other   | 989                              | 228               |
| Purchase of treasury stock   | (3,291)                          | -                 |
| Payments on debt   | -                                | (152,400)         |
| Payments on capital leases   | (138)                            | -                 |
| Funds received for the benefit of members  | 48,553                           | 48,082            |
| Net cash provided by (used in) financing activities                                  | <u>46,113</u>                    | <u>(104,090)</u>  |
| <b>Cash and cash equivalents:</b>  |                                  |                   |
| Decrease during the period   | (177,867)                        | (241,237)         |
| Balance at beginning of year   | 1,158,131                        | 1,181,922         |
| Balance at end of period   | <u>\$ 980,264</u>                | <u>\$ 940,685</u> |
| <b>SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION:</b>                            |                                  |                   |
| Cash paid for taxes  | \$ 10,725                        | \$ 2,829          |
| Cash paid for interest   | \$ -                             | \$ 2,642          |
| Property, equipment and capitalized software acquired through capital leases         | <u>\$ 8,411</u>                  | <u>\$ 559</u>     |

*See notes to unaudited condensed consolidated financial statements.*

**WELLCARE HEALTH PLANS, INC.**  
**NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS**  
**(Unaudited, in thousands, except member, per share and share data)**

**1. ORGANIZATION AND BASIS OF PRESENTATION**

WellCare Health Plans, Inc., a Delaware corporation (the “Company,” “we,” “us,” or “our”), provides managed care services exclusively to government-sponsored health care programs, focusing on Medicaid and Medicare, including health plans for families, children, and the aged, blind and disabled, serving approximately 2,184,000 members as of June 30, 2010. Our Medicaid plans include plans for beneficiaries of the Temporary Assistance for Needy Families (“TANF”) programs, Supplemental Security Income (“SSI”) programs, Aged Blind and Disabled (“ABD”) programs and state-based programs that are not part of the Medicaid program, such as Children’s Health Insurance Programs (“CHIPs”) and Family Health Plus (“FHP”). TANF generally provides assistance to low-income families with children. ABD and SSI generally provide assistance to low-income aged, blind or disabled individuals. CHIP and FHP generally provide assistance for qualifying families who are not eligible for Medicaid because they exceed the applicable income thresholds. Through our licensed subsidiaries, as of June 30, 2010, we operated our Medicaid health plans in Florida, Georgia, Hawaii, Illinois, Missouri, New York and Ohio. Our Medicare plans include stand-alone prescription drug plans (“PDPs”) in our PDP segment and Medicare Advantage (“MA”) plans in our MA segment, which, following our exit of the Medicare private fee-for-service (“PFFS”) program on December 31, 2009, is comprised of Medicare coordinated care plans (“CCPs”). As of June 30, 2010, we offered our CCPs in Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Louisiana, Missouri, New Jersey, New York, Ohio and Texas, and our PDPs in 49 states and the District of Columbia.

***Basis of Presentation***

The accompanying unaudited condensed consolidated interim financial statements should be read in conjunction with the consolidated financial statements and notes thereto for the fiscal year ended December 31, 2009 included in our Annual Report on Form 10-K (“2009 Form 10-K”), filed with the United States Securities and Exchange Commission (the “SEC”) in February 2010. In the opinion of management, the interim financial statements reflect all normal recurring adjustments that we consider necessary for the fair presentation of our financial position, results of operations and cash flows for the interim periods presented. The interim financial statements included herein have been prepared in accordance with accounting principles generally accepted in the United States of America (“GAAP”) and with the instructions to Form 10-Q and Article 10 of Regulation S-X. Accordingly, certain information and footnote disclosures normally included in financial statements prepared in accordance with GAAP have been condensed or omitted. Results for the interim periods presented are not necessarily indicative of results that may be expected for the entire year or any other interim period. Certain items in our financial statements have been reclassified from their prior year classifications to conform to our current year presentation. In addition, we have evaluated all material events subsequent to the date of our financial statements.

***Net (Loss) Income per Share***

We compute basic net (loss) income per common share on the basis of the weighted-average number of unrestricted common shares outstanding. Diluted net income per common share is computed on the basis of the weighted-average number of unrestricted common shares outstanding plus the dilutive effect of outstanding stock options, restricted shares, restricted stock units and performance stock units using the treasury stock method. The following table presents the calculation of net (loss) income per common share — basic and diluted:

|   | Three Months Ended<br>June 30, |            | Six Months Ended<br>June 30, |            |
|---|--------------------------------|------------|------------------------------|------------|
|   | 2010                           | 2009       | 2010                         | 2009       |
| <b>Numerator:</b>   |                                |            |                              |            |
| Net (loss) income   | \$ (128,871)                   | \$ 37,005  | \$ (122,453)                 | \$ 72      |
| <b>Denominator:</b>   |                                |            |                              |            |
| Weighted-average common shares outstanding — basic                            | 42,308,856                     | 41,794,997 | 42,252,018                   | 41,731,915 |
| Dilutive effect of:   |                                |            |                              |            |
| Unvested restricted stock, restricted stock units and performance stock units | -                              | 180,568    | -                            | 133,884    |
| Stock options   | -                              | 55,862     | -                            | 59,502     |
| Weighted-average common shares outstanding — diluted                          | 42,308,856                     | 42,031,427 | 42,252,018                   | 41,925,301 |
| Net (loss) income per common share:   |                                |            |                              |            |
| Basic   | \$ (3.05)                      | \$ 0.89    | \$ (2.90)                    | \$ 0.00    |
| Diluted   | \$ (3.05)                      | \$ 0.88    | \$ (2.90)                    | \$ 0.00    |

Certain options to purchase common stock were not included in the calculation of diluted net (loss) income per common share because their exercise prices were greater than the average market price of our common stock for the period and, therefore, the effect would be anti-dilutive. Due to the net loss for the three and six months ended June 30, 2010, the assumed exercise of 2,842,008 equity awards had an anti-dilutive effect and was therefore excluded from the computation of diluted loss per share. For the three and six months ended June 30, 2009, approximately 1,034,187 and 1,302,927 restricted equity awards were excluded from diluted weighted-average common shares outstanding, respectively. For both the three and six months ended June 30, 2009, approximately 3,527,628 options with exercise prices ranging from \$13.13 to \$105.37 were also excluded from diluted weighted-average common shares outstanding.

### Revenue Recognition

Our Medicaid contracts with state governments are generally multi-year contracts subject to annual renewal provisions. Our Medicare Advantage and PDP contracts with the Centers for Medicare & Medicaid Services (“CMS”) generally have terms of one year. We generally receive premiums in advance of providing services, and recognize premium revenue during the period in which we are obligated to provide services to our members. We estimate, on an ongoing basis, the amount of member and state billings that may not be fully collectible. CMS and certain states employ a risk-adjustment model to the premiums we receive whereby the ultimate premium earned is based on the beneficiaries’ health status or the attainment of a specified medical benefits ratio (“MBR”) for the population during the contract term. Our MBR represents the ratio of our medical benefits expense to the premiums we receive. We estimate the amount of premium that would be returned, if any, based on historical trends, anticipated and actual MBRs and other factors. An allowance is established for the estimated amount of premiums that may not be collectible and a liability established for premiums expected to be returned. The allowance has not been significant to premium revenue. The payment we receive monthly from CMS for our PDP program generally represents our bid amount for providing prescription drug insurance coverage. We recognize premium revenue for providing this insurance coverage ratably over the term of our annual contract. Premiums collected in advance of the period in which we are obligated to provide services to our members are deferred and reported as unearned premiums in the accompanying Condensed Consolidated Balance Sheets and amounts that have not been received by the end of the period remain on the balance sheet classified as premium receivables.

Premium payments that we receive are based upon eligibility lists produced by the government. We verify these lists to determine whether we have been paid for the correct premium category and program. From time to time, the states or CMS require us to reimburse them for premiums that we received based on an eligibility list that a state, CMS or we later discover contains individuals who were not eligible for any government-sponsored program or belong to a different plan other than ours. The verification and subsequent membership changes may result in additional amounts due to us or we may owe premiums back to the government. The amounts receivable or payable identified by us through reconciliation and verification of agency eligibility lists relate to current and prior periods. The amounts receivable from government agencies for reconciling items were \$4,691 and \$64,311 at June 30, 2010 and December 31, 2009, respectively, and are included in Premium and other receivables on our Condensed Consolidated Balance Sheets. The amounts due to government agencies for reconciling items were \$55,348 and \$105,143 at June 30, 2010 and December 31, 2009, respectively, and are included in Other accrued expenses and liabilities on our Condensed Consolidated Balance Sheets. We record adjustments to revenues based on member retroactivity. These adjustments reflect changes in the number and eligibility status of enrollees subsequent to when revenue was billed. We estimate the amount of outstanding retroactivity adjustments each period and adjust premium revenue accordingly; if appropriate, the estimates of retroactivity adjustments are based on historical trends, premiums billed, the volume of member and contract renewal activity and other information. Changes in member retroactivity adjustment

estimates had a minimal impact on premiums recorded during the periods presented. Our government contracts establish monthly rates per member, but may have additional amounts due to us based on items such as age, working status or medical history.

### ***Premium Taxes Remitted to Governmental Authorities***

Certain state agencies assess a tax on premiums remitted to us which are recorded as expense when incurred. In September 2009, the state of Georgia stopped assessing taxes on premiums remitted to us, which resulted in a corresponding reduction to Premium revenues and Selling, general and administrative expenses. However, effective July 1, 2010, the state of Georgia began assessing premium taxes again. During the three and six months ended June 30, 2010, we were assessed and remitted taxes on premiums in Hawaii, Missouri, New York and Ohio. Premium taxes for the three and six months ended June 30, 2010 were \$9,384 and \$19,128, respectively. For the three and six months ended June 30, 2009, premium taxes were \$28,780 and \$53,322, respectively.

### ***Recently Issued Accounting Standards***

In February 2010, the Financial Accounting Standards Board (the “FASB”) issued authoritative guidance related to subsequent events. This standard updates subsequent event guidance, issued in May 2009, requiring reporting entities to provide the date through which subsequent event reviews occurred, which was in conflict with certain SEC requirements. Accordingly, the update to previously issued subsequent event guidance removes the requirement to disclose a date through which subsequent events have been evaluated. The adoption of this guidance did not have a material effect on our financial statements.

In January 2010, the FASB issued authoritative guidance related to improving disclosures about fair value measurements. This standard requires reporting entities to make new disclosures about recurring or nonrecurring fair-value measurements including significant transfers into and out of Level 1 and Level 2 fair value measurements and information on purchases, sales, issuances and settlements on a gross basis in the reconciliation of Level 3 fair value measurements. This standard is effective for annual reporting periods beginning after December 15, 2009, except for Level 3 reconciliation disclosures which are effective for annual periods beginning after December 15, 2010. The adoption of this guidance has not had a material impact on our financial statements.

## **2. SEGMENT REPORTING**

Reportable operating segments are defined as components of an enterprise for which discrete financial information is available and evaluated on a regular basis by the chief operating decision-maker to determine how resources should be allocated to an individual segment and to assess performance of those segments. Previously, we reported two operating segments: Medicaid and Medicare, which coincide with our two main business lines. During the first quarter of 2010, we reassessed our segment reporting practices and made revisions to reflect our current method of managing performance and determining resource allocation, which includes reviewing the results of our PDP operations separately from other Medicare products. Accordingly, we now have three reportable segments within our two main business lines: Medicaid, MA and PDP. The PFFS product that we exited December 31, 2009 is reported within the MA segment. The prior periods have been revised to reflect this segment presentation.

Medicaid was established to provide medical assistance to low-income and disabled persons. It is state operated and implemented, although it is funded and regulated by both the state and federal governments. Our Medicaid segment includes plans for beneficiaries of TANF, SSI, ABD and state-based programs that are not part of the Medicaid program, such as CHIP and FHP for qualifying families who are not eligible for Medicaid because they exceed the applicable income thresholds. TANF generally provides assistance to low-income families with children; ABD and SSI generally provide assistance to low-income aged, blind or disabled individuals.

Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons with a variety of hospital, medical insurance and prescription drug benefits.

Our MA segment consists of MA plans, which following the exit of our PFFS product on December 31, 2009, is comprised of CCPs. MA is Medicare’s managed care alternative to original Medicare fee-for-service, which provides individuals standard Medicare benefits directly through CMS. CCPs are administered through health maintenance organizations (“HMOs”) and generally require members to seek health care services and select a primary care physician from a network of health care providers. In addition, we offer Medicare Part D coverage, which provides prescription drug benefits, as a component of our MA plans.

## [Table of Contents](#)

We offer stand-alone Medicare Part D coverage to Medicare-eligible beneficiaries in our PDP segment. The Medicare Part D prescription drug benefit is supported by risk sharing with the federal government through risk corridors designed to limit the losses and gains of the drug plans and by reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for risk factor payments. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries. The Part D program offers national in-network prescription drug coverage that is subject to limitations in certain circumstances.

Balance sheet, Investment and other income, and other expense details by segment have not been disclosed, as they are not reported internally by us. A summary of financial information for our reportable operating segments, as well as a reconciliation to (Loss) income before income taxes is presented in the table below.

|                                   | Three Months Ended<br>June 30, |           | Six Months Ended<br>June 30, |           |
|-----------------------------------|--------------------------------|-----------|------------------------------|-----------|
|                                   | 2010                           | 2009      | 2010                         | 2009      |
| Premium revenue:                  |                                |           |                              |           |
| Medicaid                          | \$                             | \$        | \$                           | \$        |
| Medicare                          |                                |           |                              |           |
| Advantage                         | 800,698                        | 813,759   | 1,609,731                    | 1,622,937 |
| PDP                               | 329,945                        | 749,813   | 681,028                      | 1,482,912 |
| Total                             | 207,294                        | 224,279   | 400,636                      | 473,929   |
| premium revenue                   | 1,337,937                      | 1,787,851 | 2,691,395                    | 3,579,778 |
| Medical benefits expense:         |                                |           |                              |           |
| Medicaid                          | 688,276                        | 691,816   | 1,390,055                    | 1,381,598 |
| Medicare                          |                                |           |                              |           |
| Advantage                         | 258,841                        | 600,258   | 535,016                      | 1,211,988 |
| PDP                               | 175,674                        | 211,945   | 363,692                      | 463,431   |
| Total medical benefits expense    | 1,122,791                      | 1,504,019 | 2,288,763                    | 3,057,017 |
| Gross margin:                     |                                |           |                              |           |
| Medicaid                          | 112,422                        | 121,943   | 219,676                      | 241,339   |
| Medicare                          |                                |           |                              |           |
| Advantage                         | 71,104                         | 149,555   | 146,012                      | 270,924   |
| PDP                               | 31,620                         | 12,334    | 36,944                       | 10,498    |
| Total gross margin                | 215,146                        | 283,832   | 402,632                      | 522,761   |
| Investment and other income       | 2,712                          | 3,427     | 5,207                        | 6,761     |
| Other expenses                    | (410,694)                      | (222,056) | (589,797)                    | (501,602) |
| (Loss) income before income taxes | \$ (192,836)                   | \$ 65,203 | \$ (181,958)                 | \$ 27,920 |

### 3. EQUITY-BASED COMPENSATION

The compensation expense recorded related to our equity-based compensation awards, which correspondingly also increased Paid-in capital, for the three months ended June 30, 2010 and 2009 was \$1,337 and \$9,630, respectively, and \$2,479 and \$19,242 for the six months ended June 30, 2010 and 2009, respectively.

Equity-based compensation expense is calculated based on awards ultimately expected to vest and has been adjusted to reflect our estimated forfeitures. We derive our forfeiture estimate at the time of grant and continuously reassess this estimate to determine if our assumptions are indicative of actual forfeitures. Our forfeiture rate assumptions vary by equity award type. For stock options issued subsequent to December 31, 2005, we increased our forfeiture rates from 28% to 40% effective June 30, 2010 to reflect actual historical and expected cancellations of unvested options due to a higher than previously estimated level of employee attrition and terminations. The differential in forfeiture rates, when applied retrospectively, resulted in an expense reversal of approximately \$4,955 for the three and six months ended June 30, 2010.

Under the 2004 Equity Incentive Plan, we granted shares to a former executive, the vesting of which and the amount of shares to be awarded was contingent upon achievement of an earnings per share target over three- and five-year performance periods. The earnings per share target for the first performance period was achieved. However, in accordance with the separation agreement between the former executive and us, issuance of those shares was subject to certain conditions that we have determined have not been, and are unlikely to be, met. Accordingly, the previously recorded compensation cost of \$4,683 was reversed during the first quarter and is included in the equity-based compensation for the six months ended June 30, 2010.

## [Table of Contents](#)

A summary of our restricted stock, restricted stock unit (“RSU”) and stock option activity for the six months ended June 30, 2010 is presented in the table below.

|   | <u>Restricted<br/>Stock and<br/>RSU</u> | <u>Weighted<br/>Average<br/>Grant-Date<br/>Fair Value</u> | <u>Options</u>   | <u>Weighted<br/>Average<br/>Exercise Price</u> |
|---|---|---|------------------|--|
| Outstanding as of January 1, 2010               | 1,339,981                               | 29.30   | 1,919,535        | 35.26  |
| Granted   | 212,813                                 | 29.67   | 104,116          | 28.93  |
| Exercised                                       | -                                       | -   | (51,597)         | 18.70  |
| Vested  | (186,994)                               | 33.00   | -                | -  |
| Forfeited and expired                           | (124,052)                               | 32.36   | (371,794)        | 45.24  |
| Outstanding at June 30, 2010                    | <u>1,241,748</u>                        | 28.51   | <u>1,600,260</u> | 33.06  |
| Exercisable at June 30, 2010                    |   |   | <u>1,127,172</u> | 35.33  |
| Vested and expected to vest as of June 30, 2010 |   |   | <u>1,431,289</u> | 33.72  |

As of June 30, 2010, there was \$35,680 of unrecognized compensation cost related to non-vested equity-based compensation arrangements that is expected to be recognized over a weighted-average period of 1.9 years.

### ***Performance Stock Units***

On March 31, 2010, the Compensation Committee of the Board of Directors awarded 168,235 Performance Stock Unit Awards (the “2010 PSU Awards”) under the 2004 Equity Incentive Plan to certain of our key employees, including executive officers. The 2010 PSU Awards vest three years from the date of grant and are subject to adjustment in the target range of 0% to 150%, based on the achievement of certain financial and quality-based performance goals set by the Compensation Committee over the three-year performance period and the employee’s continued service through the vest date. The actual number of PSUs that vest will be determined by the Compensation Committee at its sole discretion. As a result of the subjective nature of the PSUs, we have determined that, for accounting purposes, a mutual understanding of the key terms and conditions does not exist; accordingly, these awards do not have an accounting grant date. The 2010 PSU Awards ultimately expected to vest will be recognized as expense over the three-year service period based on estimated progress towards the performance measures, as well as subsequent changes in the market price of our common stock since the awards do not have an accounting grant date. The compensation expense related to our PSUs assumes that targets will be met and was \$244 for the three and six months ended June 30, 2010. As of June 30, 2010, there was \$3,222 of unrecognized compensation cost related to non-vested PSUs that is expected to be recognized over a weighted-average period of 2.8 years.

## **4. FAIR VALUE MEASUREMENTS**

Fair value measurements apply to all financial assets and financial liabilities that are being measured and reported on a fair value basis. Accounting standards require that fair value measurements be classified and disclosed in one of the following three categories: Level 1, defined as observable inputs such as quoted prices in active markets; Level 2, defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

Our Condensed Consolidated Balance Sheets include the following financial instruments: cash and cash equivalents, investments, receivables, accounts payable, medical benefits payable and amounts accrued related to the investigation resolution discussed in Note 6 to these Condensed Consolidated Financial Statements. The carrying amounts of current assets and liabilities approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization.

[Table of Contents](#)

Our Long-term investments were comprised of \$46,150 and \$57,000 of municipal note investments with an auction reset feature (“auction rate securities”), at amortized cost, as of June 30, 2010 and December 31, 2009, respectively. Liquidity for these auction rate securities is typically provided by an auction process which allows holders to sell their notes and resets the applicable interest rate at pre-determined intervals, usually every seven, 14, 28 or 35 days. Auctions for these auction rate securities continued to fail during the six months ended June 30, 2010. An auction failure means that the parties wishing to sell their securities could not be matched with an adequate volume of buyers. As a result, our ability to liquidate and fully recover the carrying value of our remaining auction rate securities in the near term may be limited or non-existent. However, when there is a failed auction, the indenture governing the security requires the issuer to pay interest at a contractually defined rate that is generally above market rates for other types of similar instruments. We continue to receive interest payments on the auction rate securities we hold. Additionally, there are government guarantees or municipal bond insurance in place and we have the ability and the present intent to hold these securities until maturity or market stability is restored. Accordingly, we do not believe our auction rate securities are impaired and as a result, we have not recorded any impairment losses for our auction rate securities. However, as these securities are believed to be in an inactive market, we have estimated the fair value of these securities using a discounted cash flow model and update these estimates on a quarterly basis. Our analysis considered, among other things, the collateralization underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows and the capital adequacy and expected cash flows of the subsidiaries that hold the securities. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties.

Our assets and liabilities measured at fair value on a recurring basis subject to the disclosure requirements of fair value accounting guidance as of June 30, 2010 and December 31, 2009, were as follows:

| Description  | Fair Value Measurements at June 30, 2010: |  |   |  |
|--|---|--|---|--|
|  | June 30, 2010                             | Quoted Prices<br>in<br>Active<br>Markets<br>Identical<br>Assets<br>(Level 1) | Significant<br>Other<br>Observable<br>(Level 2) | Significant<br>Unobservable<br>Inputs<br>(Level 3) |
| <b>Investments:</b>                                    |   |  |   |  |
| Available-for-sale securities                          |   |  |   |  |
| Certificates of deposit                                | \$ 40,553                                 | \$ 40,553  | \$ -  | \$ -   |
| Auction rate securities                                | 42,477                                    | -  | -   | 42,477   |
| Other municipal variable rate bonds                    | 4,465                                     | 4,465  | -   | -  |
| Total investments                                      | \$ 87,495                                 | \$ 45,018  | \$ -  | \$ 42,477  |
| <b>Restricted investments:</b>                         |   |  |   |  |
| Available-for-sale securities                          |   |  |   |  |
| Cash and cash equivalents                              | \$ 4,601                                  | \$ 4,601   | \$ -  | \$ -   |
| Certificates of deposit                                | 1,052                                     | 1,052  | -   | -  |
| U.S. Government securities                             | 22,282                                    | 22,282   | -   | -  |
| Money market funds                                     | 103,719                                   | 103,719  | -   | -  |
| Total restricted investments                           | \$ 131,654                                | \$ 131,654   | \$ -  | \$ -   |
| Amounts accrued related to investigation resolution(1) | \$ 327,956                                | \$ 327,956   | \$ -  | \$ -   |

(1) This amount is included in the short- and long-term portions of amounts accrued related to investigation resolution line items in our Condensed Consolidated Balance Sheets as of June 30, 2010.

| Description  | Fair Value Measurements at December 31, 2009: |  |   |  |
|--|---|--|---|--|
|  | December 31, 2009                             | Quoted Prices<br>in<br>Active<br>Markets<br>Identical<br>Assets<br>(Level 1) | Significant<br>Other<br>Observable<br>(Level 2) | Significant<br>Unobservable<br>Inputs<br>(Level 3) |
| <b>Investments:</b>                                    |   |  |   |  |
| Available-for-sale securities                          |   |  |   |  |
| Certificates of deposit                                | \$ 58,907                                     | \$ 58,907  | \$ -  | \$ -   |
| Auction rate securities                                | 51,710  | -  | -   | 51,710   |
| Other municipal variable rate bonds                    | 3,815   | 3,815  | -   | -  |
| Total investments                                      | \$ 114,432                                    | \$ 62,722  | \$ -  | \$ 51,710  |
| <b>Restricted investments:</b>                         |   |  |   |  |
| Available-for-sale securities                          |   |  |   |  |
| Cash and cash equivalents                              | \$ 4,651                                      | \$ 4,651   | \$ -  | \$ -   |
| Certificates of deposit                                | 1,051   | 1,051  | -   | -  |
| U.S. Government securities                             | 20,975  | 20,975   | -   | -  |
| Money market funds                                     | 103,873                                       | 103,873  | -   | -  |
| Total restricted investments                           | \$ 130,550                                    | \$ 130,550   | \$ -  | \$ -   |
| Amounts accrued related to investigation resolution(1) | \$ 58,397                                     | \$ -   | \$ 58,397                                       | \$ -   |

(1) This amount is included in the short- and long-term portions of amounts accrued related to investigation resolution line items in our Condensed Consolidated Balance Sheets as of December 31, 2009.

The following tables present our auction rate securities measured at fair value on a recurring basis using significant unobservable inputs (i.e., Level 3 data) for the three and six months ended June 30, 2010 and June 30, 2009.

|  | Fair Value Measurements<br>Using Significant<br>Unobservable Inputs<br>(Level 3) |                                      |
|--|--|--------------------------------------|
|  | Three Months<br>Ended<br>June 30, 2010   | Six Months<br>Ended<br>June 30, 2010 |
| Beginning balance  | \$ 45,640  | \$ 51,710                            |
| Realized gains (losses) in earnings (or changes in net assets) | -  | -                                    |
| Unrealized gains (losses) in other comprehensive income(a)     | 1,387  | 1,617                                |
| Purchases, issuances and settlements                           | -  | -                                    |
| Transfers in and/or out of Level 3(b)                          | (4,550)  | (10,850)                             |
| Ending balance at June 30, 2010                                | \$ 42,477  | \$ 42,477                            |

(a) As a result of the increase in the fair value of our investments in auction rate securities, we recorded a net unrealized gain of \$1,387 and \$1,617 to Accumulated other comprehensive loss for the three and six months ended June 30, 2010, respectively. The increase in unrealized gain was driven by stabilization and improvement within the municipal bond market during the first half of 2010.

(b) Auction rate securities in the amount of \$6,300 and \$4,550 were redeemed by the issuer at par in March and May 2010, respectively. Accordingly, we recorded an adjustment to the fair market valuation of the issuers' auction rate securities during the first and second quarter of 2010.

|  | <b>Fair Value Measurements<br/>Using Significant<br/>Unobservable Inputs<br/>(Level 3)</b> |   |
|--|--|---|
|  | <b>Three Months<br/>Ended<br/>June 30, 2009</b>  | <b>Six Months<br/>Ended<br/>June 30, 2009</b> |
|  | Beginning balance  | \$ 48,404                                     |
| Realized gains (losses) in earnings (or changes in net assets) | -  | -   |
| Unrealized gains in other comprehensive income(a)              | 3,084  | 916   |
| Purchases, issuances and settlements                           | -  | -   |
| Transfers in and/or out of Level 3(b)                          | -  | (4,400)                                       |
| Ending balance at June 30, 2009                                | <u>\$ 51,488</u>   | <u>\$ 51,488</u>                              |

- (a) As a result of the increase in the fair value of our investments in auction rate securities, we recorded a net unrealized gain of \$3,084 and \$916 to Accumulated other comprehensive loss for the three and six months ended June 30, 2009, respectively. The increase in unrealized gain was driven by the stabilization and improvement within the municipal bond market during the second quarter of 2009.
- (b) A \$4,400 auction rate security was redeemed by the issuer at par in February 2009. Accordingly, we recorded an adjustment to the fair market valuation of the issuer's auction rate securities during the first quarter of 2009.

## 5. DEBT

We entered into a credit agreement on May 12, 2010, which was subsequently amended on May 25, 2010 (as amended, the "Credit Agreement"). The Credit Agreement provides for a \$65,000 committed revolving credit facility that expires on November 12, 2011. Borrowings under the Credit Agreement may be used for general corporate purposes.

The Credit Agreement is guaranteed by us and our subsidiaries, other than our HMO and insurance subsidiaries. In addition, the Credit Agreement is secured by first priority liens on our personal property and the personal property of our subsidiaries, other than the personal property and equity interests of our HMO and insurance subsidiaries.

Borrowings designated by us as Alternate Base Rate borrowings bear interest at a rate per annum equal to (i) the greatest of (a) the Prime Rate (as defined in the Credit Agreement) in effect on such day; (b) the Federal Funds Effective Rate (as defined in the Credit Agreement) in effect on such day plus 1/2 of 1%; and (c) the Adjusted LIBO Rate (as defined in the Credit Agreement) for a one month interest period on such day plus 1%; plus (ii) 1.5%. Borrowings designated by us as Eurodollar borrowings bear interest at a rate per annum equal to the Adjusted LIBO Rate for the interest period in effect for such borrowing plus 2.5%.

The Credit Agreement includes negative covenants that limit certain of our activities, including restrictions on our ability to incur additional indebtedness, and financial covenants that require a minimum ratio of cash flow to total debt, a maximum ratio of total liabilities to consolidated net worth and a minimum level of statutory net worth for our HMO and insurance subsidiaries.

The Credit Agreement also contains customary representations and warranties that must be accurate in order for us to borrow under the Credit Agreement. In addition, the Credit Agreement contains customary events of default. If an event of default occurs and is continuing, we may be required to immediately repay all amounts outstanding under the Credit Agreement, and the commitments under the Credit Agreement may be terminated.

As of June 30, 2010, the credit facility has not been drawn upon and we remain in compliance with all covenants.

## 6. COMMITMENTS AND CONTINGENCIES

### *Government Investigations*

As previously disclosed, in May 2009, we entered into a Deferred Prosecution Agreement (the “DPA”) with the United States Attorney’s Office for the Middle District of Florida (the “USAO”) and the Florida Attorney General’s Office, resolving previously disclosed investigations by those offices.

Under the one-count criminal information (the “Information”) filed with the United States District Court for the Middle District of Florida (the “Federal Court”) by the USAO pursuant to the DPA, we were charged with one count of conspiracy to commit health care fraud against the Florida Medicaid Program in connection with reporting of expenditures under certain community behavioral health contracts, and against the Florida Healthy Kids programs, under certain contracts, in violation of 18 U.S.C. Section 1349. The USAO recommended to the Court that the prosecution be deferred for the duration of the DPA. Within five days of the expiration of the DPA the USAO will seek dismissal with prejudice of the Information, provided we have complied with the DPA.

The term of the DPA is thirty-six months, but such term may be reduced by the USAO to twenty-four months upon consideration of certain factors set forth in the DPA, including our continued remedial actions and compliance with all federal and state health care laws and regulations.

In accordance with the DPA, the USAO has filed, with the Federal Court, a statement of facts relating to this matter. As a part of the DPA, we have retained an independent monitor (the “Monitor”) for a period of 18 months from his retention in August 2009. The Monitor was selected by the USAO after consultation with us and is retained at our expense. In addition, we agreed to continue undertaking remedial measures to ensure full compliance with all federal and state health care laws. Among other things, the Monitor is reviewing our compliance with the DPA and all applicable federal and state health care laws, regulations and programs. The Monitor also is reviewing, evaluating and, as necessary, making written recommendations concerning certain of our policies and procedures. The DPA provides that the Monitor will undertake to avoid the disruption of our ordinary business operations or the imposition of unnecessary costs or expenses.

The DPA does not, nor should it be construed to, operate as a settlement or release of any civil or administrative claims for monetary, injunctive or other relief against us, whether under federal, state or local statutes, regulations or common law. Furthermore, the DPA does not operate, nor should it be construed, as a concession that we are entitled to any limitation of our potential federal, state or local civil or administrative liability. Pursuant to the terms of the DPA, we have paid the USAO a total of \$80,000.

In May 2009, we resolved the previously disclosed investigation by the SEC. Under the terms of the Consent and Final Judgment, without admitting or denying the allegations in the complaint filed by the SEC, we consented to the entry of a permanent injunction against any future violations of certain specified provisions of the federal securities laws. Pursuant to the terms of the Consent and Final Judgment, we have paid the SEC a total of \$10,000.

In October 2008, the Civil Division of the United States Department of Justice (the “Civil Division”) informed us that as part of the pending civil inquiry, it is investigating four *qui tam* complaints filed by relators against us under the whistleblower provisions of the False Claims Act, 31 U.S.C. sections 3729-3733. The seal in those cases was partially lifted for the purpose of authorizing the Civil Division to disclose to us the existence of the *qui tam* complaints. In May 2010, as part of the ongoing resolution discussions with the Civil Division, we were provided with a copy of the *qui tam* complaints, in response to our request, which otherwise remained under seal as required by 31 U.S.C. section 3730(b)(3).

As previously disclosed, we also learned from a docket search that a former employee filed a *qui tam* action on October 25, 2007 in state court for Leon County, Florida against several defendants, including us and one of our subsidiaries (the “Leon County *qui tam* suit”). As part of our discussions to resolve pending *qui tam* and related civil investigations discussed above, we have been informed that the Leon County *qui tam* suit was filed by one of the federal *qui tam* relators and contains allegations similar to those alleged in one of the recently unsealed *qui tam* complaints.

On June 24, 2010, (i) the United States government filed its Notice of Election to Intervene in three of the *qui tam* matters, and (ii) we announced that we reached a preliminary agreement (the “Preliminary Settlement”) with the Civil Division, the Civil Division of the USAO, and the Civil Division of the United States Attorney’s Office for the District of Connecticut to settle their pending inquiries. On June 25, 2010, the Federal Court lifted the seal in the three *qui tam* complaints in which the government had intervened. Those complaints are now publicly available.

The Preliminary Settlement is subject to completion and approval of an executed written settlement agreement and other government approvals. If any party objects to the Preliminary Settlement, the Federal Court will conduct a hearing to determine whether the proposed settlement is fair, adequate and reasonable under all the circumstances. Upon execution of the settlement agreement, we would, among other things, agree to pay the Civil Division a total of \$137,500 (the "Settlement Amount"), for which the first installment will be due after a written settlement agreement has been executed and three subsequent installments will be paid over a period of up to 36 months after the date of that executed written settlement agreement (the "Payment Period") plus interest at the rate of 3.125% per year. The Preliminary Settlement includes an acceleration clause that would require immediate payment of the remaining balance of the Settlement Amount in the event that we were acquired or otherwise experienced a change in control during the Payment Period. In addition, the Preliminary Settlement provides for a contingent payment of an additional \$35,000 in the event that we are acquired or otherwise experience a change in control within three years of the execution of the settlement agreement and provided that the change in control transaction exceeds certain minimum transaction value thresholds to be specified in the settlement agreement. We expect that the final settlement agreement will provide that the Settlement Amount will include approximately \$22,938 owed to the Florida Agency for Health Care Administration ("AHCA") as a result of overpayments received by us from AHCA during the three month period of August 2005 through October 2005. These overpayments were the result of a change implemented by AHCA in the payment methodology relating to medical benefits for newborns. We previously had recorded this liability and had been in discussions with AHCA regarding the reconciliation and repayment of this overpayment. The previously accrued AHCA overpayments of \$22,938, which was recorded in the Other accrued expenses and liabilities, was reclassified to the Current portion of amounts accrued related to investigation resolution line item in our Condensed Consolidated Balance Sheet as of June 30, 2010.

We have discounted the total liability of \$137,500 for the resolution of these matters and accrued this amount at its estimated fair value, which amounted to approximately \$134,028 at June 30, 2010. In connection with the resolution of these matters, approximately \$54,682 was accrued during the three months ended June 30, 2010 to increase the amount we had previously recorded in prior periods to reflect our current estimate. A total expense of approximately \$55,193 has been accrued during the six months ended June 30, 2010 in connection with the resolution of these matters. Approximately \$31,172 and \$102,856 has been included in the current and long-term portions, respectively, of amounts accrued related to the investigation resolution in our Condensed Consolidated Balance Sheet as of June 30, 2010. There can be no assurance that the Preliminary Settlement will be finalized and approved and the actual outcome of these matters may differ materially from the terms of the Preliminary Settlement.

As previously disclosed, we remain engaged in resolution discussions as to matters under review with the United States Department of Health and Human Services' Office of Inspector General (the "OIG"). Those discussions are ongoing and no final resolution has been reached.

### ***Putative Class Action Complaints***

Putative class action complaints were filed in October 2007 and in November 2007. These putative class actions, entitled Eastwood Enterprises, L.L.C. v. Farha, et al. and Hutton v. WellCare Health Plans, Inc. et al., respectively, were filed in Federal Court against us, Todd Farha, our former chairman and chief executive officer, and Paul Behrens, our former senior vice president and chief financial officer. Messrs. Farha and Behrens were also officers of various subsidiaries of ours. The Eastwood Enterprises complaint alleges that the defendants materially misstated our reported financial condition by, among other things, purportedly overstating revenue and understating expenses in amounts unspecified in the pleading in violation of the Securities Exchange Act of 1934, as amended ("Exchange Act"). The Hutton complaint alleges that various public statements supposedly issued by the defendants were materially misleading because they failed to disclose that we were purportedly operating our business in a potentially illegal and improper manner in violation of applicable federal guidelines and regulations. The complaint asserts claims under the Exchange Act. Both complaints seek, among other things, certification as a class action and damages. The two actions were consolidated, and various parties and law firms filed motions seeking to be designated as Lead Plaintiff and Lead Counsel. In an Order issued in March 2008, the Federal Court appointed a group of five public pension funds from New Mexico, Louisiana and Chicago (the "Public Pension Fund Group") as Lead Plaintiffs. In October 2008, an amended consolidated complaint was filed in this class action asserting claims against us, Messrs. Farha and Behrens, and adding Thaddeus Bereday, our former senior vice president and general counsel, as a defendant. In January 2009, we and certain other defendants filed a joint motion to dismiss the amended consolidated complaint, arguing, among other things, that the complaint failed to allege a material misstatement by defendants with respect to our compliance with marketing and other health care regulations and failed to plead facts raising a strong inference of scienter with respect to all aspects of the purported fraud claim. The Federal Court denied the motion in September 2009 and we and the other defendants filed our answer to the amended consolidated complaint in November 2009.

In April 2010, the Lead Plaintiffs filed their motion for class certification. On June 18, 2010, the USAO filed motions seeking to intervene and for a temporary stay of discovery of this matter. In July 2010, the Federal Court granted the United States' motions and ordered that discovery be stayed until December 2010.

On August 6, 2010, we reached agreement with the Lead Plaintiffs on the material terms of a settlement to resolve this matter. The terms of the settlement will be documented in a formal settlement agreement which will require approval by the Federal Court following notice to all class members. The settlement provides that we will make cash payments to the class of \$52,500 within thirty business days following the Federal Court's preliminary approval of the settlement and \$35,000 by July 31, 2011. The settlement also provides that we will issue to the class tradable unsecured bonds having an aggregate face value of \$112,500, with a fixed coupon of 6% and a maturity date of December 31, 2016. The bonds shall also provide that, if we incur debt obligations in excess of \$425,000 that are senior to the bonds, the bonds shall accelerate as to payment and be redeemed. The settlement has two further contingencies. First, it provides that if, within three years following the date of the settlement agreement, the Company is acquired or otherwise experiences a change in control at a share price of \$30.00 or more, we will pay to the class an additional \$25,000. Second, the settlement provides that we will pay to the class 25% of any sums we recover from Messrs. Farha, Behrens and/or Bereday as a result of claims arising from the same facts and circumstances that gave rise to this matter. We may terminate the settlement if a certain number or percentage of the class opt out of the settlement class. The settlement agreement will also provide that the settlement does not constitute an admission of liability by any party and such other terms as are customarily contained in settlement agreements of similar matters.

As a result of this settlement having been reached, our current estimate for the resolution of this matter is \$200,000. We have discounted the \$200,000 liability for the resolution of this matter and accrued this amount at its estimated fair value, which amounted to approximately \$193,928 at June 30, 2010. Approximately \$52,500 and \$141,428 have been included in the current and long-term portions, respectively, of amounts accrued related to investigation resolution in our Condensed Consolidated Balance Sheet as of June 30, 2010. There can be no assurance that the settlement will be finalized and approved and the actual outcome of this matter may differ materially from the terms of the settlement.

### ***Derivative Lawsuits***

As previously disclosed, in connection with our government investigations, five putative stockholder derivative actions were filed between October and November 2007. Four of these actions were asserted against directors Kevin Hickey and Christian Michalik, our current directors who were directors prior to 2007, and against former directors Regina Herzlinger, Alif Hourani, Ruben King-Shaw and Neal Moskowski, and former director and officer Todd Farha. These actions also name us as a nominal defendant. Two of these actions were filed in the Federal Court and two actions were filed in the Circuit Court for Hillsborough County, Florida (the "State Court"). The fifth action, filed in the Federal Court, asserts claims against directors Robert Graham, Kevin Hickey and Christian Michalik, our current directors who were directors at the time the action was filed, and against former directors Regina Herzlinger, Alif Hourani, Ruben King-Shaw and Neal Moskowski, former director and officer Todd Farha, and former officers Paul Behrens and Thaddeus Bereday. A sixth derivative action was filed in January 2008 in the Federal Court and asserted claims against all of these defendants except Robert Graham. All six of these actions contend, among other things, that the defendants allegedly allowed or caused us to misrepresent our reported financial results, in amounts unspecified in the pleadings, and seek damages and equitable relief for, among other things, the defendants' supposed breach of fiduciary duty, waste and unjust enrichment. In April 2009, upon the recommendation of the Nominating and Corporate Governance Committee of the Board, the Board formed a Special Litigation Committee, comprised of a newly-appointed independent director, to investigate the facts and circumstances underlying the claims asserted in the derivative cases and to take such action with respect to these claims as the Special Litigation Committee determines to be in our best interests. In November 2009, the Special Litigation Committee filed a report with the Federal Court determining, among other things, that we should pursue an action against three of our former officers. In December 2009, the Special Litigation Committee filed a motion to dismiss the claims against the director defendants and to realign us as a plaintiff for purposes of pursuing claims against former officers Messrs. Farha, Behrens and Bereday.

In March 2010, a Stipulation of Partial Settlement ("Stipulation I") was filed in the Federal Court. Under the terms of Stipulation I, the plaintiffs in the federal action have agreed that the Special Litigation Committee's motion to dismiss the director defendants and to realign us as a plaintiff should be granted in its entirety. The plaintiffs in the consolidated federal putative shareholder derivative actions also agreed to dismiss their claims against Messrs. Farha, Behrens and Bereday. In turn, we have paid to plaintiffs' counsel in the federal action attorneys' fees in the amount of \$1,688. This amount was accrued during the first quarter of 2010 and has been included in the Other accrued expenses and liabilities line item in

## [Table of Contents](#)

our Condensed Consolidated Balance Sheet as of June 30, 2010. In April 2010, the Federal Court entered an order preliminarily approving Stipulation I and directing us to provide notice to our shareholders. The Federal Court also approved Stipulation I and granted our motion to dismiss the director defendants and realigned us as the plaintiff in this action in July 2010. The case is now styled *WellCare v. Farha, et al.* In July 2010, the Federal Court stayed discovery until December 2010.

In April 2010, a second Stipulation of Partial Settlement (“Stipulation II”) was filed in the State Court. Under the terms of Stipulation II, the plaintiffs in the state action agreed that the Special Litigation Committee’s motion to dismiss the director defendants and to realign us as a plaintiff should be granted in its entirety. In turn, we have paid to plaintiffs’ counsel in the state action attorneys’ fees in the amount of \$563. This amount was also accrued during the first quarter of 2010 and is included in the Other accrued expenses and liabilities line item in our Condensed Consolidated Balance Sheet as of June 30, 2010. The State Court approved Stipulation II and granted our motion to dismiss the director defendants and realigned us as the plaintiff in this action in June 2010. In July 2010, Mr. Farha filed a Notice of Appeal in this matter.

### ***Other Lawsuits and Claims***

In October 2009, an action was filed against us in the Court of Chancery of the State of Delaware entitled *Behrens, et al. v. WellCare Health Plans, Inc.* in which the plaintiffs, Messrs. Behrens, Bereday, and Farha, seek an order requiring us to pay their respective expenses, including attorney fees, in connection with litigation and investigations in which the plaintiffs are involved by reason of their service as our directors and officers. Plaintiffs further challenge our right, prior to advancing such expenses, to first submit their expense invoices to our directors’ and officers’ insurance carrier for their preliminary review and evaluation of the adequacy of the description of services in the invoices and of the reasonableness of those expenses. We have reached an agreement in principle to resolve this matter and will continue to pay their respective expenses, including attorney fees, under certain terms, in connection with the investigations and litigation.

Separate and apart from the legal matters described above, we are also involved in other legal actions that are in the normal course of our business, including, without limitation, provider disputes regarding payment of claims, disputes relating to the performance of contractual obligations with state agencies and disputes with state tax authorities, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We currently believe that none of these actions, when finally concluded and determined, will have a material adverse effect on our financial position, results of operations or cash flows.

## **Item 2. Management’s Discussion and Analysis of Financial Condition and Results of Operations.**

### **Forward Looking Statements**

This Quarterly Report on Form 10-Q for the quarterly period ended June 30, 2010 (“2010 Form 10-Q”) may include “forward-looking statements” within the meaning of Section 21E of the Securities Act of 1934, as amended, including, in particular, estimates, projections, guidance or outlook. Generally the words “believe,” “expect,” “anticipate,” “may,” “intend,” “estimate,” “anticipate,” “plan,” “project,” “should” and similar expressions, identify forward-looking statements, which generally are not historical in nature. These statements may contain information about financial prospects, economic conditions and trends that involve risks and uncertainties. Please refer to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2009 (“2009 Form 10-K”), “Forward Looking Statements” and “Risk Factors” in our Quarterly Report on Form 10-Q for the three months ended March 31, 2010 and to Part II, Item 1A - Risk Factors, in this 2010 Form 10-Q, for a discussion of certain risk factors which could materially affect our business, financial condition, cash flows, or results of operations. If any of those risks, or other risks not presently known to us or that we currently believe to not be significant, do materialize or develop into actual events, our business, financial condition, results of operations or prospects could be materially adversely affected. Given these risks and uncertainties, we can give no assurances that any results or events projected or contemplated by our forward-looking statements will in fact occur and we caution you not to place undue reliance on these statements. We caution you that we do not undertake any obligation to update forward-looking statements made by us.

### **Overview**

#### ***Executive Summary***

We provide managed care services exclusively to government-sponsored health care programs, serving approximately 2.2 million members as of June 30, 2010. We believe that our broad range of experience and exclusive government focus allows us to efficiently and effectively serve our members and providers, while managing our ongoing operations. Our strategic priorities for 2010 include improving health care quality and access for our members, ensuring a competitive cost position and committing to prudent and profitable growth. We continue to work closely with providers and government clients to further enhance health care delivery; improving the quality of, and enhancing access to, government health care services for our members. Our cost management initiatives are concentrated on aligning our expense structure with our current revenue base through process improvement and other initiatives; focusing on ensuring a competitive cost position in terms of both administrative and medical expenses. We are also focused on programs that help governments provide quality care within their fiscal constraints and present us with long-term opportunities for prudent and profitable growth.

#### ***General Economic and Political Environment***

The current economic and political environment is affecting our business in a number of ways, as more fully described throughout this 2010 Form 10-Q.

#### ***Premium Rates and Payments***

The states in which we operate continue to experience fiscal challenges which have led to budget cuts and reductions in Medicaid premiums in certain states or rate increases that are below medical cost trends. In particular, we continue to experience pressure on rates in Florida and Georgia, two states from which we derive a substantial portion of our revenue. In addition, although premiums are generally contractually payable to us before or during the month in which we are obligated to provide services to our members, we have experienced delays in premium payments from certain states. In particular, the State of Georgia recently passed legislation mandating payment at the end of the month services are provided for our Medicaid program in that state. Although this legislation becomes effective in June 2011, the State of Georgia has already implemented this change. Prior to this change, such payments were made at the beginning of each month. Given the budget shortfalls in many states with which we contract, additional payment delays may occur in the future. In addition to these Medicaid challenges, the Centers for Medicare & Medicaid Services (“CMS”) implemented 2010 Medicare Advantage (“MA”) payment rates that are at or slightly below 2009 rates.

In 2009, as part of the American Recovery and Reinvestment Act, Congress increased the Federal Medical Assistance Percentages (“FMAP”), temporarily increasing federal funding for state Medicaid programs. The policy rationale was to help relieve states’ fiscal problems in the face of declining revenues and rising Medicaid enrollments due to the economic downturn. The enhanced FMAP is set to expire at the end of 2010. The Senate and House of Representatives have separately passed legislation extending additional enhanced FMAP funding through June 2011. While we anticipate Congress will reach consensus prior to the end of the calendar year, some states may realize less federal revenue than expected. State budget shortfalls could result in program cuts, which could impact our premium or membership.

## *Health Care Reform*

In March 2010, President Obama signed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the “2010 Acts”). We believe these laws will bring about significant changes to the American health care system. While these measures are intended to expand the number of United States citizens covered by health insurance and make other coverage, delivery, and payment changes to the current health care system, the costs of implementing the 2010 Acts will be financed, in part, by future reductions in the payments made to Medicare providers.

Having passed new health legislation, the federal government now faces the task of implementing the 2010 Acts throughout the system. We are reviewing the newly-enacted legislation and its potential effects on MA payments. We believe that any revisions to the existing system may put pressure on operating results, decrease member benefits, and/or increase member premiums, particularly with respect to MA plans.

The health reforms in the 2010 Acts present several challenges as well as opportunities for our Medicaid business. We anticipate that the reforms could significantly increase the number of citizens who are eligible to enroll in our Medicaid products. However, state budgets continue to be strained due to economic conditions and uncertain levels of federal financing for current populations. As a result, the effects of any potential future expansions are uncertain, making it difficult to determine whether the 2010 Acts will have a positive or negative impact on our Medicaid business.

The 2010 Acts include a number of changes to the way MA plans will be compensated in the future. Beginning in 2012, MA plan premiums will be tied to quality measures and based on a CMS “5-star rating system.” This rating system allows an MA plan to receive an increase in certain premium rates. It is unknown whether these ratings will be geographically or demographically adjusted. The final methodology used in the determination of our quality score, which continues to be developed by CMS, could impact our ability to provide additional benefits and entice new members.

## ***Business and Financial Outlook***

### *Business Trends*

Our revenues and medical benefits expenses for fiscal year 2010 will be lower than in prior periods due to our exit on December 31, 2009 from our MA private fee-for-service (“PFFS”) product and our exit from Medicaid programs in certain Florida counties during 2009. Premium revenue from our PFFS product represented approximately 40.9% of our MA reportable operating segment revenue and 16.5% of our consolidated premium revenue for the 2009 fiscal year. We anticipate that the withdrawal from the PFFS product may provide approximately \$40.0 million to \$60.0 million of excess capital in the insurance companies that underwrote this line of business, which we may be able to distribute to our unregulated subsidiaries through dividends. However, we currently believe we will not have the benefit of these dividends prior to 2011, if at all. Any dividend of surplus capital of our applicable insurance subsidiaries, including the timing and amount of any dividend, would be subject to a variety of factors, which could materially change the aforementioned timing and amount. Those factors include the ultimate financial performance of the PFFS product as well as the financial performance of other lines of business that operate in those insurance subsidiaries, approval from regulatory agencies and potential changes in regulatory capital requirements. For example, our current estimate of \$40.0 million to \$60.0 million declined from previous estimates, because the financial performance of these insurance subsidiaries worsened during 2009 and 2010.

During 2009, CMS imposed a marketing sanction against us that prohibited us from the marketing of, and enrollment into, all lines of our Medicare business from March until the sanction was released in November. As a result of the sanction, we were not eligible to receive auto-assignments of low-income subsidy (“LIS”), dual-eligible beneficiaries into our prescription drug plans (“PDP”), for January 2010 enrollment. We received auto-assignments of such members in subsequent months, although such assignments were at levels well below the level we typically experience in the month of January.

As of June 30, 2010, we serve members in our PDP programs in 49 states and the District of Columbia.

### *Financial Impact of Government Investigations and Litigation*

As previously disclosed, pursuant to our consent to the entry of a final judgment against us in the United States District Court for the Middle District of Florida (the “Federal Court”) to resolve the previously disclosed informal investigation conducted by the United States Securities and Exchange Commission (the “SEC”), we have paid a civil penalty in the aggregate amount of \$10.0 million and disgorgement in the amount of one dollar plus post-judgment interest. As previously disclosed, we remain engaged in resolution discussions as to matters under review with the United States Department of Health and Human Services’ Office of Inspector General (the “OIG”).

In June 2010 we announced that we had reached a preliminary agreement (the “Preliminary Settlement”) with the United States Department of Justice’s Civil Division (the “Civil Division”) to settle its inquiries. The Preliminary Settlement is subject to, among other things, completion of an executed written settlement agreement and other government approvals. Pursuant to the terms of the Preliminary Settlement we would agree to, among other things, pay the Civil Division a total of \$137.5 million, for which the first installment will be due after an agreement has been executed and three subsequent installments will be paid over a period of up to 36 months after the date of that executed agreement plus interest at the rate of 3.125% per year. We have discounted the total liability of \$137.5 million for the resolution of these matters and accrued this amount at its estimated fair value, which amounted to approximately \$134.0 million at June 30, 2010. In connection with the resolution of these matters, approximately \$54.7 million was accrued during the three months ended June 30, 2010 to increase the amount we had previously recorded in prior periods to reflect our current estimate. A total expense of approximately \$55.2 million has been accrued during the six months ended June 30, 2010 in connection with the resolution of these matters. Approximately \$31.2 million and \$102.8 million have been included in the current and long-term portions, respectively, of amounts accrued related to the investigation resolution as of June 30, 2010. There can be no assurance that the Preliminary Settlement will be finalized and approved and the actual outcome of these matters may differ materially from the terms of the Preliminary Settlement. For additional information regarding the Preliminary Settlement and the anticipated agreement, please see “Legal Proceedings” below.

In April 2010, the Lead Plaintiffs in the putative class action complaints filed against us in 2007 entitled *Eastwood Enterprises, L.L.C. v. Farha, et al.* and *Hutton v. WellCare Health Plans, Inc. et al.*, filed their motion for class certification. On June 18, 2010, the USAO filed motions seeking to intervene and for a temporary stay of discovery of this matter. In July 2010, the Federal Court granted the United States’ motions and ordered that discovery be stayed until December 2010. On August 6, 2010, we reached agreement with the Lead Plaintiffs on the material terms of a settlement to resolve this matter. The terms of the settlement will be documented in a formal settlement agreement which will require approval by the Federal Court following notice to all class members. The settlement provides that we will make cash payments to the class of \$52.5 million within thirty business days following the Federal Court’s preliminary approval of the settlement and \$35.0 million by July 31, 2011. The settlement also provides that we will issue to the class tradable unsecured bonds having an aggregate face value of \$112.5 million, with a fixed coupon of 6% and a maturity date of December 31, 2016. The bonds shall also provide that, if we incur debt obligations in excess of \$425.0 million that are senior to the bonds, the bonds shall accelerate as to payment and be redeemed. The settlement has two further contingencies. First, it provides that if, within three years following the date of the settlement agreement, the Company is acquired or otherwise experiences a change in control at a share price of \$30.00 or more, we will pay to the class an additional \$25.0 million. Second, the settlement provides that we will pay to the class 25% of any sums we recover from Messrs. Farha, Behrens and/or Bereday as a result of claims arising from the same facts and circumstances that gave rise to this matter. We may terminate the settlement if a certain number or percentage of the class opt out of the settlement class. The settlement agreement will also provide that the settlement does not constitute an admission of liability by any party and such other terms as are customarily contained in settlement agreements of similar matters.

As a result of this settlement having been reached, our current estimate for the resolution of this matter is \$200.0 million. We have discounted the \$200.0 million liability for the resolution of this matter and accrued this amount at its estimated fair value, which amounted to approximately \$193.9 million at June 30, 2010. Approximately \$52.5 million and \$141.4 million have been included in the current and long-term portions, respectively, of amounts accrued related to investigation resolution in our Condensed Consolidated Balance Sheet as of June 30, 2010. There can be no assurances that the ultimate resolution of this matter will not have a material adverse effect on our financial position, results of operations or cash flow.

#### *Investigation Related Costs*

We have expended significant financial resources in connection with the investigations and related matters. Since the inception of these investigations through June 30, 2010, we have incurred a total of approximately \$177.7 million for administrative expenses associated with, or consequential to, these governmental and Company investigations for legal fees, accounting fees, consulting fees, employee recruitment and retention costs and other similar expenses. We have received approximately \$6.7 million in insurance proceeds through June 30, 2010 to offset these administrative costs. For the three and six months ended June 30, 2010, we incurred approximately \$7.8 million and \$8.6 million in these investigation-related administrative expenses, respectively, and \$12.4 million and \$23.9 million in costs, respectively, for the same three and six month periods in the prior year. We expect to continue incurring additional costs in connection with the resolution of these matters including shareholder actions and compliance with the previously disclosed Deferred Prosecution Agreement we entered in May 2009 with the United States Attorney’s Office for the Middle District of Florida and the Florida Attorney General’s Office, resolving previously disclosed investigations by those offices and related matters during its term. Although investigation related costs have gradually declined overall, we can provide no assurance that such costs will not be significant or increase in the future.

## Basis of Presentation

### *Segments*

Reportable operating segments are defined as components of an enterprise for which discrete financial information is available and evaluated on a regular basis by the chief operating decision-maker to determine how resources should be allocated to an individual segment and to assess performance of those segments. Previously, we reported two operating segments: Medicaid and Medicare, which coincide with our two main business lines. During the first quarter of 2010, we reassessed our segment reporting practices and made revisions to reflect our current method of managing performance and determining resource allocation, which includes reviewing the results of our PDP operations separately from other Medicare products. Accordingly, we now have three reportable segments within our two main business lines: Medicaid, MA and PDP. The PFFS product that we exited December 31, 2009 is reported within the MA segment. The prior periods have been revised to reflect this segment presentation.

We use three measures to assess the performance of our reportable business segments: premium revenue, medical benefits ratio (“MBR”) and gross margin. Our MBR represents the ratio of our medical benefits expense to the premiums we receive. Our gross margin is defined as our premium revenue less our medical benefits expense.

Our profitability depends in large part on our ability to, among other things, effectively price our health and prescription drug plans; manage medical benefits expense, including reserve estimates and pharmacy costs; contract with health care providers; and attract and retain members. In addition, factors such as regulation, competition and general economic conditions affect our operations and profitability. The effect of escalating health care costs, as well as any changes in our ability to negotiate competitive rates with our providers may impose further risks to our profitability and may have a material impact on our business, financial condition and results of operations.

### *Medicaid*

Medicaid was established to provide medical assistance to low-income and disabled persons. It is state operated and implemented, although it is funded and regulated by both the state and federal governments. Our Medicaid segment includes plans for beneficiaries of the Temporary Assistance for Needy Families (“TANF”) programs, Supplemental Security Income (“SSI”) programs, Aged Blind and Disabled (“ABD”) programs and state-based programs that are not part of the Medicaid program, such as Children’s Health Insurance Programs (“CHIPs”) and Family Health Plus (“FHP”) programs for qualifying families who are not eligible for Medicaid because they exceed the applicable income thresholds. TANF generally provides assistance to low-income families with children; ABD and SSI generally provide assistance to low-income aged, blind or disabled individuals.

The Medicaid programs and services we offer to our members vary by state and county and are designed to serve our various constituencies effectively in the communities we serve. Although our Medicaid contracts determine to a large extent the type and scope of health care services that we arrange for our members, in certain markets we customize our benefits in ways that we believe make our products more attractive. Our Medicaid plans provide our members with access to a broad spectrum of medical benefits from many facets of primary care and preventive programs to full hospitalization and tertiary care.

In general, members are required to use our network, except in cases of emergencies, transition of care or when network providers are unavailable to meet their medical needs, and generally must receive a referral from their primary care physician (“PCP”) in order to receive health care from specialists, such as surgeons or neurologists. Members do not pay any premiums, deductibles or co-payments for most of our Medicaid plans.

### *Medicare Advantage*

Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons a variety of hospital, medical and prescription drug benefits. Our MA segment consists of MA plans, which following the exit of our PFFS product on December 31, 2009, is comprised of coordinated care plans (“CCPs”). MA is Medicare’s managed care alternative to original Medicare fee-for-service (“Original Medicare”), which provides individuals standard Medicare benefits directly through CMS. CCPs are administered through health maintenance organizations (“HMOs”) and generally require members to seek health care services and select a PCP from a network of health care providers. In addition, we offer Medicare Part D coverage, which provides prescription drug benefits, as a component of our MA plans.

## [Table of Contents](#)

We cover a wide spectrum of medical services through our MA plans, including in some cases, additional benefits not covered by Original Medicare, such as vision, dental and hearing services. Through these enhanced benefits, the out-of-pocket expenses incurred by our members are reduced, which allows our members to better manage their health care costs.

Most of our MA plans require members to pay a co-payment, which varies depending on the services and level of benefits provided. Typically, members of our MA CCPs are required to use our network of providers except in cases such as emergencies, transition of care or when specialty providers are unavailable to meet a member's medical needs. MA CCP members may see an out-of-network specialist if they receive a referral from their PCP and may pay incremental cost-sharing. In most of our markets, we also offer special needs plans to individuals who are dually eligible for Medicare and Medicaid. These plans, commonly called D-SNPs, are designed to provide specialized care and support for beneficiaries who are eligible for both Medicare and Medicaid. We believe that our D-SNPs are attractive to these beneficiaries due to the enhanced benefit offerings and clinical support programs.

### *Prescription Drug Plans*

We offer stand-alone Medicare Part D coverage to Medicare-eligible beneficiaries through our PDP segment. The Medicare Part D prescription drug benefit is supported by risk sharing with the federal government through risk corridors designed to limit the losses and gains of the drug plans and by reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for risk factor payments. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries. The Medicare Part D program offers national in-network prescription drug coverage that is subject to limitations in certain circumstances.

Depending on medical coverage type, a beneficiary has various options for accessing drug coverage. Beneficiaries enrolled in Original Medicare can either join a stand-alone PDP or forego Part D drug coverage. Beneficiaries enrolled in MA CCPs can join a plan with Part D coverage, select a separate Part D plan, or forego Part D coverage.

### **Gross Margin and Medical Benefits Ratio**

Our primary tools for measuring profitability are gross margin and MBR. Changes in gross margin and MBR from period to period result from, among other things, changes in Medicaid and Medicare funding, changes in the mix of Medicaid and Medicare membership, our ability to manage medical costs and changes in accounting estimates related to claims incurred but not reported ("IBNR"). Estimation of medical benefits payable and medical benefits expense is our most significant critical accounting estimate. See "Critical Accounting Estimates" below. We use gross margin and MBRs both to monitor our management of medical benefits expense and to make various business decisions, including what health care plans to offer, what geographic areas to enter or exit and which health care providers to select. Although gross margin and MBRs play an important role in our business strategy, we may be willing to enter new geographical markets and/or enter into provider arrangements that might produce a less favorable gross margin and MBR if those arrangements, such as capitation or risk sharing, would likely lower our exposure to variability in medical costs or for other reasons.

### **Critical Accounting Estimates**

In the ordinary course of business, we make a number of estimates and assumptions relating to the reporting of our results of operations and financial condition in conformity with accounting principles generally accepted in the United States. We base our estimates on historical experience and on various other assumptions that we believe to be reasonable under the circumstances. Actual results could differ significantly from those estimates under different assumptions and conditions. We believe that our accounting policies relating to revenue recognition, medical benefits payable and medical benefits expense, and goodwill and intangible assets, are those that are most important to the portrayal of our financial condition and results and require management's most difficult, subjective and complex judgments, often as a result of the need to make estimates about the effect of matters that are inherently uncertain. We have not changed these policies from those previously disclosed in our 2009 Form 10-K. Our critical accounting estimates relating to medical benefits payable and medical benefits expense, and the quantification of the sensitivity of financial results to reasonably possible changes in the underlying assumptions used in such estimation as of June 30, 2010, is discussed below. Additionally, we continually assess our estimates related to goodwill and intangible assets, which is discussed in further detail below. There were no significant changes to the other critical accounting estimates disclosed in our 2009 Form 10-K.

*Estimating Medical Benefits Payable and Medical Benefits Expense*

The cost of medical benefits is recognized in the period in which services are provided and includes an estimate of the cost of IBNR medical benefits. Medical benefits expense has two main components: direct medical expenses and medically-related administrative costs. Direct medical expenses include amounts paid or payable to hospitals, physicians and providers of ancillary services, such as laboratory and pharmacy. Medically-related administrative costs include items such as case and disease management, utilization review services, quality assurance and on-call nurses, which are recorded in Selling, General, and Administrative Expenses. Medical benefits payable on our Condensed Consolidated Balance Sheets represents amounts for claims fully adjudicated awaiting payment disbursement of \$58.8 million and \$53.0 million, and estimates for IBNR of \$601.3 million and \$749.5 million, as of June 30, 2010 and December 31, 2009, respectively.

The medical benefits payable estimate has been and continues to be our most significant estimate included in our financial statements. We historically have used and continue to use a consistent methodology for estimating our medical benefits expense and medical benefits payable. Our policy is to record management's best estimate of medical benefits payable based on the experience and information available to us at the time. This estimate is determined utilizing standard actuarial methodologies based upon historical experience and key assumptions consisting of trend factors and completion factors using an assumption of moderately adverse conditions, which vary by business segment. These standard actuarial methodologies include using, among other factors, contractual requirements, historic utilization trends, the interval between the date services are rendered and the date claims are paid, denied claims activity, disputed claims activity, benefits changes, expected health care cost inflation, seasonality patterns, maturity of lines of business and changes in membership.

The factors and assumptions described above that are used to develop our estimate of medical benefits expense and medical benefits payable inherently are subject to greater variability when there is more limited experience or information available to us. The ultimate claims payment amounts, patterns and trends for new products and geographic areas cannot be precisely predicted at their onset, since we, the providers and the members do not have experience in these products or geographic areas. Standard accepted actuarial methodologies, discussed above, would allow for this inherent variability, which could result in larger differences between the originally estimated medical benefits payable and the actual claims amounts paid. Conversely, during periods where our products and geographies are more stable and mature, we have more reliable claims payment patterns and trend experience. With more reliable data, we should be able to more closely estimate the ultimate claims payment amounts; therefore, we may experience smaller differences between our original estimate of medical benefits payable and the actual claim amounts paid.

In developing our estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For the more recent months, which constitute the majority of the amount of the medical benefits payable, we estimate claims incurred by applying observed trend factors to the fixed fee per-member per-month ("PMPM") costs for prior months, which costs have been estimated using completion factors, in order to estimate the PMPM costs for the most recent months. We validate our estimates of the most recent PMPM costs by comparing the most recent months' utilization levels to the utilization levels in prior months and actuarial techniques that incorporate a historical analysis of claim payments, including trends in cost of care provided and timeliness of submission and processing of claims.

Many aspects of the managed care business are not predictable. These aspects include the incidences of illness or disease state (such as cardiac heart failure cases, cases of upper respiratory illness, the length and severity of the flu season, diabetes, the number of full-term versus premature births and the number of neonatal intensive care babies). Therefore, we must continually monitor our historical experience in determining our trend assumptions to reflect the ever-changing mix, needs and size of our membership. Among the factors considered by management are changes in the level of benefits provided to members, seasonal variations in utilization, identified industry trends and changes in provider reimbursement arrangements, including changes in the percentage of reimbursements made on a capitation as opposed to a fee-for-service basis. These considerations are reflected in the trends in our medical benefits expense. Other external factors such as government-mandated benefits or other regulatory changes, catastrophes and epidemics may impact medical cost trends. Other internal factors such as system conversions and claims processing interruptions may impact our ability to accurately predict estimates of historical completion factors or medical cost trends. Medical cost trends potentially are more volatile than other segments of the economy. Management uses considerable judgment in determining medical benefits expense trends and other actuarial model inputs. We believe that the amount of medical benefits payable as of June 30, 2010 is adequate to cover our ultimate liability for unpaid claims as of that date; however, actual payments may differ from established estimates. If the completion factors we used in estimating our IBNR for the most recent six months at June 30, 2010 were decreased by 1%, our net income would decrease by approximately \$30.0 million. If the completion factors were increased by 1%, our net income would increase by approximately \$29.3 million.

Also included in medical benefits payable are estimates for provider settlements due to clarification of contract terms, out-of-network reimbursement, claims payment differences as well as amounts due to contracted providers under risk-sharing arrangements. We record reserves for estimated referral claims related to health care providers under contract with us who are financially troubled or insolvent and who may not be able to honor their obligations for the costs of medical services provided by other providers. In these instances, we may be required to honor these obligations for legal or business reasons. Based on our current assessment of providers under contract with us, such losses have not been and are not expected to be significant.



## [Table of Contents](#)

Changes in medical benefits payable estimates are primarily the result of obtaining more complete claims information and medical expense trend data over time. Volatility in members' needs for medical services, provider claims submissions and our payment processes result in identifiable patterns emerging several months after the causes of deviations from assumed trends occur. Since our estimates are based upon PMPM claims experience, changes cannot typically be explained by any single factor, but are the result of a number of interrelated variables, all influencing the resulting experienced medical cost trend. Differences in our financial statements between actual experience and estimates used to establish the liability, which we refer to as prior period developments, are recorded in the period when such differences become known, and have the effect of increasing or decreasing the reported medical benefits expense and resulting MBR in such periods.

In establishing our estimate of reserves for IBNR at each reporting period, we use standard actuarial methodologies based upon historical experience and key assumptions consisting of trend factors and completion factors, which vary by business segment, to determine an estimate of the base reserve. Actuarial standards of practice require that a margin for uncertainty be considered in determining the estimate for unpaid claim liabilities. If a margin is included, the claim liabilities should be adequate under moderately adverse conditions. Therefore, we make an additional estimate in the process of establishing the IBNR, which also uses standard actuarial techniques, to account for adverse conditions that may cause actual claims to be higher than estimated compared to the base reserve, for which the model is not intended to account for. We refer to this additional liability as the provision for moderately adverse conditions. The provision for moderately adverse conditions is a component of our overall determination of the adequacy of our IBNR. The provision for moderately adverse conditions is intended to capture the potential adverse development from factors such as our entry into new geographical markets, our provision of services to new populations such as the aged, blind and disabled, the variations in utilization of benefits and increasing medical cost, changes in provider reimbursement arrangements, variations in claims processing speed and patterns, claims payment, the severity of claims, and outbreaks of disease such as the flu. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNR after considering the base actuarial model reserves and the provision for moderately adverse conditions. We consistently apply our IBNR estimation methodology from period to period. We review our overall estimates of IBNR on a monthly basis. As additional information becomes known to us, we adjust our assumptions accordingly to change our estimate of IBNR. Therefore, if moderately adverse conditions do not occur, evidenced by more complete claims information in the following period, then our prior period estimates will be revised downward, resulting in favorable development. However, any favorable prior period reserve development would affect (increase) current period net income only to the extent that the current period provision for moderately adverse conditions is less than the benefit recognized from the prior period favorable development. If moderately adverse conditions occur and are more than we estimated, then our prior period estimates will be revised upward, resulting in unfavorable development, which would decrease current period net income.

For the three months ended June 30, 2010, medical benefits expense was impacted by approximately \$14.5 million of net favorable development related to prior periods, which includes approximately \$27.6 million of favorable development related to prior fiscal years that was partially offset by \$13.2 million of unfavorable development that related to earlier periods in 2010. For the six months ended June 30, 2010, medical benefits expense was impacted by approximately \$32.2 million of net favorable development related to prior years. For the three months ended June 30, 2009, medical benefits expense was impacted by approximately \$8.7 million of net favorable development related to prior periods, which included approximately \$16.1 million of favorable development related to prior fiscal years that was partially offset by \$7.4 million of unfavorable development that related to earlier periods in 2009. For the six months ended June 30, 2009, medical benefits expense was impacted by approximately \$46.1 million of net favorable development related to prior years. The favorable prior period developments in the 2010 periods are primarily associated with the exit of our PFFS product on December 31, 2009 and the unfavorable development recognized in the three months ended June 30, 2010 that related to earlier periods in 2010, was primarily due to higher than expected medical services that was not discernable until the impact became clearer over time as claim payments were processed. The net amount of prior period developments in the 2009 periods were primarily attributable to pricing assumptions, early durational effect favorability, the volatility associated with our new and small blocks of MA business, which were converted from the loss ratio methodology to the development factor methodology in 2009 (both methodologies are recognized methods for estimating claim reserves in accordance with actuarial standards of practice), the recovery by us of claim overpayments on our PFFS product that exceeded our estimates and better than expected demographic mix of membership. The factors impacting the changes in the determination of reserve balances discussed above were not discernable in advance. The impact became clearer over time as claim payments were processed and more complete claims information was obtained.

*Goodwill and Intangible Assets*

We review goodwill and intangible assets for impairment at least annually, or more frequently if events or changes in circumstances occur that may affect the estimated useful life or the recoverability of the remaining balance of goodwill or intangible assets. Events or changes in circumstances would include significant changes in membership, state funding, medical contracts and provider networks. We evaluate the impairment of goodwill and intangible assets using both the income and market approach. In doing so, we must make assumptions and estimates, such as the discount factor, in determining the estimated fair values. While we believe these assumptions and estimates are appropriate, other assumptions and estimates could be applied and might produce significantly different results. An impairment loss is recognized for goodwill and intangible assets if the carrying value of such assets exceeds its fair value. We select the second quarter of each year for our annual impairment test, which generally coincides with the finalization of federal and state contract negotiations and our initial budgeting process. The results of our annual impairment test are expected to be completed during the third quarter of 2010. We have assessed the book value of goodwill and other intangible assets and reviewed for any triggering events that may have occurred during the period and we determined that there were no indications of impairment as of June 30, 2010.

In addition, we have evaluated the intangible assets in connection with our PFFS exit on December 31, 2009, which primarily consisted of state licenses for the insurance companies that underwrote that line of business. As we continue to use these company licenses for other lines of business and the licenses have a market value, we determined that these assets have not been impaired as of June 30, 2010.

**Results of Operations**

*Three and Six Month Periods Ended June 30, 2010 Compared to the Three and Six Month Periods Ended June 30, 2009*

**Summary of Financial Information:**

The following tables set forth condensed consolidated statements of income data, as well as other key data used in our results of operations discussion. Results for the interim periods presented are not necessarily indicative of results that may be expected for the entire year or any other interim period.

| Consolidated Income Statement Data:        | Three Months Ended June 30, |                | \$ Variance       | % Variance    |
|--|-----------------------------|----------------|-------------------|---------------|
|  | 2010                        | 2009           |                   |               |
| <b>Revenues:</b>                           |                             |                |                   |               |
| Premium                                    | \$ 1,337.9                  | \$ 1,787.9     | \$ (450.0)        | -25.2%        |
| Investment and other income                | 2.7                         | 3.4            | (0.7)             | -20.6%        |
| Total revenues                             | <u>1,340.6</u>              | <u>1,791.3</u> | <u>(450.7)</u>    | <u>-25.2%</u> |
| <b>Expenses:</b>                           |                             |                |                   |               |
| Medical benefits                           | 1,122.8                     | 1,504.0        | (381.2)           | -25.3%        |
| Selling, general and administrative        | 404.7                       | 215.1          | 189.6             | 88.2%         |
| Depreciation and amortization              | 5.9                         | 6.0            | (0.1)             | -1.7%         |
| Interest                                   | 0.0                         | 1.0            | (1.0)             | n/m           |
| Total expenses                             | <u>1,533.4</u>              | <u>1,726.1</u> | <u>(192.7)</u>    | <u>-11.2%</u> |
| (Loss) income before income taxes          | (192.8)                     | 65.2           | (258.0)           | n/m           |
| Income tax (benefit) expense               | (63.9)                      | 28.2           | (92.1)            | n/m           |
| Net (loss) income                          | <u>\$ (128.9)</u>           | <u>\$ 37.0</u> | <u>\$ (165.9)</u> | <u>n/m</u>    |
| <b>Net (loss) income per common share:</b> |                             |                |                   |               |
| Basic                                      | \$ (3.05)                   | \$ 0.89        |                   |               |
| Diluted                                    | \$ (3.05)                   | \$ 0.88        |                   |               |
| Membership                                 | 2,184,000                   | 2,388,000      |                   |               |
| Consolidated MBR                           | 83.9%                       | 84.1%          |                   |               |

| Consolidated Income Statement Data:        | Six Months Ended June 30, |                | \$ Variance       | % Variance    |
|--|---------------------------|----------------|-------------------|---------------|
|  | 2010                      | 2009           |                   |               |
| <b>Revenues:</b>                           |                           |                |                   |               |
| Premium                                    | \$ 2,691.4                | \$ 3,579.8     | \$ (888.4)        | -24.8%        |
| Investment and other income                | 5.2                       | 6.7            | (1.5)             | -22.4%        |
| Total revenues                             | <u>2,696.6</u>            | <u>3,586.5</u> | <u>(889.9)</u>    | <u>-24.8%</u> |
| <b>Expenses:</b>                           |                           |                |                   |               |
| Medical benefits                           | 2,288.8                   | 3,057.0        | (768.2)           | -25.1%        |
| Selling, general and administrative        | 578.1                     | 486.8          | 91.3              | 18.8%         |
| Depreciation and amortization              | 11.7                      | 11.7           | (0.0)             | -0.9%         |
| Interest                                   | 0.0                       | 3.1            | (3.1)             | n/m           |
| Total expenses                             | <u>2,878.6</u>            | <u>3,558.6</u> | <u>(680.0)</u>    | <u>-19.1%</u> |
| (Loss) income before income taxes          | (182.0)                   | 27.9           | (209.9)           | n/m           |
| Income tax (benefit) expense               | (59.5)                    | 27.8           | (87.3)            | n/m           |
| Net (loss) income                          | <u>\$ (122.5)</u>         | <u>\$ 0.1</u>  | <u>\$ (122.6)</u> | <u>n/m</u>    |
| <b>Net (loss) income per common share:</b> |                           |                |                   |               |
| Basic                                      | \$ (2.90)                 | \$ 0.00        |                   |               |
| Diluted                                    | \$ (2.90)                 | \$ 0.00        |                   |               |
| Membership                                 | 2,184,000                 | 2,388,000      |                   |               |
| Consolidated MBR                           | 85.0%                     | 85.4%          |                   |               |

n/m Indicates percentage change between these years is considered either not measurable or not meaningful.

### Summary of Consolidated Financial Results:

#### Premium Revenue

Premium revenue for the three months ended June 30, 2010 decreased \$450.0 million, or 25.2%, to \$1,337.9 million from \$1,787.9 million for the same period in the prior year. For the six months ended June 30, 2010, premium revenues decreased \$888.4 million, or 24.8%, to approximately \$2,691.4 million from approximately \$3,579.8 million for the same period in the prior year. The decrease in premium revenue is primarily attributable to the decline in membership in our PDP and MA segments, with the exit from our PFFS product accounting for the majority of MA premium reductions as discussed in the respective section below, and to a lesser extent, from elimination of the premium tax associated with the Medicaid revenues in Georgia during the fourth quarter of 2009. Total membership decreased by approximately 204,000 members from 2,388,000 as of June 30, 2009 to 2,184,000 as of June 30, 2010.

#### Investment and Other Income

Investment and other income for the three months ended June 30, 2010 decreased \$0.7 million, or 20.6%, to \$2.7 million from \$3.4 million for the same period in the prior year. For the six months ended June 30, 2010, investment and other income decreased \$1.5 million, or 22.4%, to \$5.2 million from \$6.7 million for the same period in the prior year. The decrease was primarily due to reduced market rates on lower average investment and cash balances.

#### Medical Benefits Expense

Medical benefits expense for the three months ended June 30, 2010 decreased \$381.2 million, or 25.3%, to \$1,122.8 million from \$1,504.0 million for the same period in the prior year. For the six months ended June 30, 2010, medical benefits expense decreased \$768.2 million, or 25.1%, to approximately \$2,288.8 million from \$3,057.0 million for the same period in the prior year. The decrease in medical benefits expense for both the three and six months ended June 30, 2010 is primarily due to the exit from our PFFS product and the decline in membership and premiums, as well as improved performance in our PDP segment. The consolidated MBR was 83.9% and 84.1% for the three months ended June 30, 2010 and 2009, respectively. For the six months ended June 30, 2010, the consolidated MBR was 85.0% compared to 85.4% for the same period in the prior year. The decline in MBR for the three and six months ended June 30, 2010 compared to the same periods in the prior year is primarily due to the exit from our PFFS product and improved performance of our PDP segment.

*Selling, General and Administrative Expense*

Selling, general and administrative (“SG&A”) expense for the three and six months ended June 30, 2010 includes \$256.4 million and \$257.7 million, respectively, of expense related to the resolution of certain governmental and Company investigations and related litigation. SG&A expense for the three and six months ended June 30, 2009 includes \$27.4 million and \$83.7 million, respectively, of such expenses. The resolution amounts include \$193.9 million that we accrued as our current estimate for resolution of the putative class action complaints during the three months ended June 30, 2010, as well as \$54.7 million and \$59.8 million that we accrued related to the settlement of investigations by the Civil Division during the three months ended June 30, 2010 and 2009, respectively. After excluding these resolution amounts, our SG&A expense decreased by \$39.3 million, or 20.9%, and \$82.7 million, or 20.5%, during the three and six months ended June 30, 2010 compared to the same periods in 2009. The decrease for both periods resulted principally from the exit of our PFFS product, elimination of the premium tax associated with the Georgia Medicaid program in the fourth quarter of 2009, which reduced SG&A expense in 2010 relative to 2009, as well as gains in operating efficiency, offset in part by increased costs for MA CCP marketing and infrastructure investments.

Our SG&A expense as a percentage of revenue (“SG&A ratio”) was 30.2% for the three months ended June 30, 2010 compared to 12.0% for the same period in the prior year. For the six months ended June 30, 2010, our SG&A ratio was 21.4% compared to 13.6% for the same period in the prior year. After excluding the resolution amounts discussed above, our SG&A ratio for the three and six months ended June 30, 2010 was 11.1% and 11.9%, respectively, compared to 10.5% and 11.2% for the three and six months ended June 30, 2009, respectively. Our SG&A ratio increased for both the three and six months ended June 30, 2010 mainly due to a lower revenue base in 2010 resulting from the exit from our PFFS product and the impact of the 2009 CMS marketing sanction, partially offset by the factors reducing our SG&A expense discussed above.

*Income Tax (Benefit) Expense*

Income tax benefit for the three months ended June 30, 2010 was \$63.9 million compared to \$28.2 million of income tax expense for the same period in the prior year, with an effective tax rate of 33.2% and 43.2% for the three months ended June 30, 2010 and 2009, respectively. The income tax benefit for the six months ended June 30, 2010 was \$59.5 million with an effective tax rate of 32.7% as compared to \$27.8 million of income tax expense for the same six-month period in the prior year with an effective tax rate of 99.7%. The fluctuation in the effective tax rate for the three and six months ended June 30, 2010 compared to the same periods in 2009 was primarily attributable to the impact of non-deductible SG&A expenses associated with the resolution of certain governmental and Company investigations.

*Net (Loss) Income*

Net loss for the three months ended June 30, 2010 was \$128.9 million, compared to \$37.0 million of net income for the same period in 2009. For the six months ended June 30, 2010, the net loss was \$122.5 million compared to \$0.1 million of net income for the same period in 2009. The net losses for both periods in 2010, when compared to the same periods in 2009, is primarily due to increased amounts incurred in 2010 related to the resolution of certain governmental and Company investigations, the loss of gross margin from the withdrawal of our PFFS product and decreased premium revenue from our MA CCP and PDP segments, partially offset by improvement in our MBR and reduction in SG&A expenses, excluding the resolution amounts.

***Reconciling Segment Results:***

The following table reconciles our reportable segment results with our (loss) income before income taxes, as reported under accounting principles generally accepted in the United States of America.

| Reconciling Segment Results Data: | Three Months Ended June 30, |              | Six Months Ended June 30, |              |
|-----------------------------------|-----------------------------|--------------|---------------------------|--------------|
|                                   | 2010                        | 2009         | 2010                      | 2009         |
| <b>Gross Margin:</b>              |                             |              |                           |              |
| Medicaid                          | \$ 112.4                    | \$ 121.9     | \$ 219.7                  | \$ 241.3     |
| Medicare Advantage                | 71.1                        | 149.6        | 146.0                     | 270.9        |
| PDP                               | 31.6                        | 12.4         | 36.9                      | 10.5         |
| <b>Total gross margin</b>         | <b>215.1</b>                | <b>283.9</b> | <b>402.6</b>              | <b>522.7</b> |
| Investment and other income       | 2.7                         | 3.4          | 5.2                       | 6.8          |
| Other expenses                    | 410.6                       | 222.1        | 589.8                     | 501.6        |
| (Loss) income before income taxes | \$ (192.8)                  | \$ 65.2      | \$ (182.0)                | \$ 27.9      |

**Medicaid Segment Results:**

| Medicaid Segment Results Data: | Three Months Ended June 30, |                  | Six Months Ended June 30, |                 |
|--------------------------------|-----------------------------|------------------|---------------------------|-----------------|
|                                | 2010                        | 2009             | 2010                      | 2009            |
| Premium revenue                | \$ 800.7                    | \$ 813.7         | \$ 1,609.8                | \$ 1,622.9      |
| Medical benefits expense       | 688.3                       | 691.8            | 1,390.1                   | 1,381.6         |
| <b>Gross margin</b>            | <b>\$ 112.4</b>             | <b>\$ 121.9</b>  | <b>\$ 219.7</b>           | <b>\$ 241.3</b> |
| <b>Medicaid Membership:</b>    |                             |                  |                           |                 |
| TANF                           | 1,071,000                   | 1,076,000        |                           |                 |
| S-CHIP                         | 168,000                     | 162,000          |                           |                 |
| SSI and ABD                    | 78,000                      | 83,000           |                           |                 |
| FHP                            | 11,000                      | 16,000           |                           |                 |
|                                | <b>1,328,000</b>            | <b>1,337,000</b> |                           |                 |
| Medicaid MBR                   | 86.0%                       | 85.0%            | 86.4%                     | 85.1%           |

Medicaid premium revenue for the three months ended June 30, 2010 decreased \$13.0 million to \$800.7 million from \$813.7 million for the same period in the prior year. Medicaid premium revenue for the six months ended June 30, 2010 decreased \$13.1 million to \$1,609.8 million from \$1,622.9 million for the same period in the prior year. The decrease in premium revenue for both periods was mainly due to the elimination of the premium tax associated with the Georgia Medicaid program in the fourth quarter of 2009 and the decrease in membership in Florida and New York, partially offset by rate increases in most markets and membership growth in Georgia. Membership decreased by approximately 9,000 members to 1,328,000 as of June 30, 2010, from 1,337,000 as of June 30, 2009. Medicaid medical benefits expense for the three months ended June 30, 2010 decreased \$3.5 million to \$688.3 million from \$691.8 million from the same period in the prior year due to lower membership. Medicaid medical benefits expense for the six months ended June 30, 2010 increased \$8.5 million to \$1,390.1 million from \$1,381.6 million in the prior year mainly due to the impact of favorable reserve development experienced in 2009, partially offset by an improvement in MBR excluding the impact of prior period favorable reserve development experienced in 2009. The increase in Medicaid MBR for both the three and six months ended June 30, 2010 is mainly from the elimination of the Georgia premium tax and higher costs associated with our Hawaii operations, premium increases during the past year that were below our medical cost trend and the impact of favorable reserve development experienced in 2009 that exceeded the favorable impact of the reserve development in 2010.

**Medicare Advantage Segment Results:**

| MA Segment Results Data: | Three Months Ended June 30, |          | Six Months Ended June 30, |            |
|--------------------------|-----------------------------|----------|---------------------------|------------|
|                          | 2010                        | 2009     | 2010                      | 2009       |
| Premium revenue          | \$ 329.9                    | \$ 749.8 | \$ 681.0                  | \$ 1,482.9 |
| Medical benefits expense | 258.8                       | 600.2    | 535.0                     | 1,212.0    |
| Gross margin             | \$ 71.1                     | \$ 149.6 | \$ 146.0                  | \$ 270.9   |
| MA Membership            | 115,000                     | 253,000  |                           |            |
| MA MBR                   | 78.4%                       | 80.1%    | 78.6%                     | 81.7%      |

Our MA segment includes results from the PFFS product that we exited on December 31, 2009. MA premium revenue for the three months ended June 30, 2010 decreased \$419.9 million to \$329.9 million from \$749.8 million for the same period in the prior year. MA premium revenue for the six months ended June 30, 2010 decreased \$801.9 million to \$681.0 million from \$1,482.9 million for the same period in prior year. Membership decreased by approximately 138,000 members to 115,000 as of June 30, 2010, from 253,000 as of June 30, 2009. The decrease in MA premium revenue and membership was primarily attributable to the PFFS withdrawal and reduced MA CCP membership due to our being unable to enroll new members during the 2009 CMS marketing sanction. Correspondingly, MA gross margin for the three and six months ended June 30, 2010 decreased by \$78.5 million and \$124.9 million, respectively, compared to the same periods in the prior year due to the decrease in premiums, partially offset by prior period favorable medical benefit reserve development related to the PFFS product. The decrease in the MA MBR for both the three and six months ended June 30, 2010 was primarily related to the withdrawal of PFFS plans, which operated at an MBR above the segment average and, to a lesser extent, the prior period favorable reserve development related to the PFFS product.

**Prescription Drug Plan Segment Results:**

| PDP Segment Results Data: | Three Months Ended June 30, |          | Six Months Ended June 30, |          |
|---------------------------|-----------------------------|----------|---------------------------|----------|
|                           | 2010                        | 2009     | 2010                      | 2009     |
| Premium revenue           | \$ 207.3                    | \$ 224.3 | \$ 400.6                  | \$ 473.9 |
| Medical benefits expense  | 175.7                       | 211.9    | 363.7                     | 463.4    |
| Gross margin              | \$ 31.6                     | \$ 12.4  | \$ 36.9                   | \$ 10.5  |
| PDP Membership            | 741,000                     | 798,000  |                           |          |
| PDP MBR                   | 84.8%                       | 94.5%    | 90.8%                     | 97.8%    |

PDP premium revenue for the three months ended June 30, 2010 decreased \$17.0 million to \$207.3 million from \$224.3 million for the same period in the prior year. PDP premium revenue for the six months ended June 30, 2010 decreased \$73.3 million to \$400.6 million from \$473.9 million for the same period in the prior year. The decrease in PDP premium revenue in both periods was due primarily to a decline in membership. Membership decreased by approximately 57,000 members to 741,000 as of June 30, 2010 from 798,000 as of June 30, 2009 as a result of our inability to enroll new members during the 2009 CMS marketing sanction. PDP MBR improved for both the three and six months ended June 30, 2010 due to improved performance of the product. PDP gross margin for the three months ended June 30, 2010 increased \$19.2 million to \$31.6 million from \$12.4 million for the same period in the prior year. PDP gross margin for the six months ended June 30, 2010 increased \$26.4 million to \$36.9 million from \$10.5 million for the same period in the prior year. The improvement in gross margin for both periods was due mainly to better overall performance of the Part D product, partially offset by the decrease in premiums.

## Liquidity and Capital Resources

### Overview

Each of our existing and anticipated sources of cash is impacted by operational and financial risks that influence the overall amount of cash generated and the capital available to us. For a further discussion of risks that can affect our liquidity, see “Risk Factors” in Part 1 – Item 1A included in our 2009 Form 10-K.

### Cash Positions

As of June 30, 2010, our consolidated cash and cash equivalents were approximately \$980.3 million, our consolidated investments were approximately \$87.5 million, our unregulated cash was approximately \$157.4 million and our unregulated investments were approximately \$2.7 million. As of December 31, 2009, our consolidated cash and cash equivalents were approximately \$1,158.1 million, our consolidated investments were approximately \$114.4 million, our unregulated cash was approximately \$117.6 million and our unregulated investments were approximately \$2.8 million.

During the three months ended June 30, 2010, we received \$25.0 million in dividends from one of our regulated subsidiaries, which increased our unregulated cash. We currently believe that we will be able to meet our known near-term monetary obligations and maintain sufficient liquidity to operate our business. However, one or more of our regulators could require one or more of our subsidiaries to maintain minimum levels of statutory net worth in excess of the amount required under the applicable state laws if the regulators were to determine that such a requirement were in the interest of our members. Further, there may be other potential adverse developments that could impede our ability to meet our obligations.

### Initiatives to Increase Our Unregulated Cash

We are pursuing alternatives to raise additional unregulated cash. Some of these initiatives include, but are not limited to, consideration of obtaining dividends from certain of our regulated subsidiaries to the extent that we are able to access any available excess capital and accessing the credit markets. However, we cannot provide any assurances that we will obtain applicable state regulatory approvals for additional dividends to our non-regulated subsidiaries by our regulated subsidiaries. In addition to dividends, our strategies include accessing the public equity markets and potentially selling assets.

### Credit Facility

We entered into a credit agreement on May 12, 2010, which was subsequently amended on May 25, 2010 (as amended, the “Credit Agreement”). The Credit Agreement provides for a \$65.0 million committed revolving credit facility that expires on November 12, 2011. Borrowings under the Credit Agreement may be used for general corporate purposes.

The Credit Agreement is guaranteed by us and our subsidiaries, other than our HMO and insurance subsidiaries. In addition, the Credit Agreement is secured by first priority liens on our personal property and the personal property of our subsidiaries, other than the personal property and equity interests of our HMO and insurance subsidiaries.

Borrowings designated by us as Alternate Base Rate borrowings bear interest at a rate per annum equal to (i) the greatest of (a) the Prime Rate (as defined in the Credit Agreement) in effect on such day; (b) the Federal Funds Effective Rate (as defined in the Credit Agreement) in effect on such day plus 1/2 of 1%; and (c) the Adjusted LIBO Rate (as defined in the Credit Agreement) for a one month interest period on such day plus 1%; plus (ii) 1.5%. Borrowings designated by us as Eurodollar borrowings bear interest at a rate per annum equal to the Adjusted LIBO Rate for the interest period in effect for such borrowing plus 2.5%.

The Credit Agreement includes negative covenants that limit certain of our activities, including restrictions on our ability to incur additional indebtedness, and financial covenants that require a minimum ratio of cash flow to total debt, a maximum ratio of total liabilities to consolidated net worth and a minimum level of statutory net worth for our HMO and insurance subsidiaries.

The Credit Agreement also contains customary representations and warranties that must be accurate in order for us to borrow under the Credit Agreement. In addition, the Credit Agreement contains customary events of default. If an event of default occurs and is continuing, we may be required to immediately repay all amounts outstanding under the Credit Agreement, and the commitments under the Credit Agreement may be terminated.

As of June 30, 2010, the credit facility has not been drawn upon and we remain in compliance with all covenants.

### Auction Rate Securities

As of June 30, 2010, all of our long-term investments were comprised of municipal note investments with an auction reset feature ("auction rate securities"). These auction rate securities are issued by various state and local municipal entities for the purpose of financing student loans, public projects and other activities; they carry an investment grade credit rating. Although auctions continue to fail, we believe we will be able to liquidate these securities without significant loss, and we currently believe these securities are not impaired, primarily due to government guarantees or municipal bond insurance and our ability and present intent to hold these securities until maturity or market stability is restored; however, it could take until the final maturity of the underlying securities to realize our investments' recorded value. In March and May 2010, auction rate securities in the amount of \$6.3 million and \$4.6 million, respectively, were called at par, at the option of the issuer. We currently have the ability and present intent to hold our auction rate securities until maturity or market stability is restored with respect to these securities.

### Overview of Cash Flow Activities

For the six-month periods ended June 30, 2010 and 2009 our cash flows are summarized as follows:

|   | Six Months Ended June 30, |            |
|---|---------------------------|------------|
|   | 2010                      | 2009       |
|   | (In millions)             |            |
| Net cash used in operating activities               | \$ (244.6)                | \$ (150.0) |
| Net cash provided by investing activities           | 20.6                      | 12.8       |
| Net cash provided by (used in) financing activities | 46.1                      | (104.1)    |

*Cash used in Operating Activities:* Because we generally receive premiums in advance of payments of claims for health care services, we maintain balances of cash and cash equivalents pending payment of claims. Our net loss for the six months ended June 30, 2010 was \$122.5 million. Cash used in operations consisted of primarily a \$142.4 million pay down of medical benefits payable, primarily the result of claim payments in 2010 relating to the PFFS product that we exited on December 31, 2009, unearned premiums that decreased \$90.4 million and accounts payable and other accrued expenses that decreased \$43.7 million.

*Cash provided by Investing Activities:* During the six months ended June 30, 2010, investing activities consisted primarily of the net proceeds from the sale and maturity of investments totaling approximately \$28.6 million, partially offset by the purchases of additions to property and equipment totaling approximately \$6.9 million.

*Cash provided by (used in) Financing Activities:* Included in financing activities are funds held for the benefit of members, which increased approximately \$48.6 million as of June 30, 2010. These PDP member subsidies represent pass-through payments from government partners and are not accounted for in our results of operations since they represent payments to fund deductibles, co-payments and other member benefits for certain of our members that normally fluctuate.

### Item 3. Quantitative and Qualitative Disclosures about Market Risk.

As of June 30, 2010, we had cash and cash equivalents of \$980.3 million, investments classified as current assets of \$45.0 million, long-term investments of \$42.5 million and restricted investments on deposit for licensure of \$131.7 million. The short-term investments classified as current assets consist of highly liquid securities with maturities between three and twelve months and longer term bonds with floating interest rates that are considered available for sale. Long-term restricted assets consist of cash and cash equivalents deposited or pledged to state agencies in accordance with state rules and regulations. These restricted assets are classified as long term regardless of the contractual maturity date due to the long-term nature of the states' requirements. The restricted investments classified as long term are subject to interest rate risk and will decrease in value if market rates increase. Because of their short-term pricing nature, however, we would not expect the value of these investments to decline significantly as a result of a sudden change in market interest rates. Assuming a hypothetical and immediate 1.0% increase in market interest rates at June 30, 2010 the fair value of our fixed income short-term investments would increase by less than \$0.1 million. Similarly, a 1.0% decrease in market interest rates at June 30, 2010 would result in a decrease of the fair value of our short-term investments of less than \$0.5 million.

**Item 4. Controls and Procedures.**

***Evaluation of Disclosure Controls and Procedures***

Our management carried out an evaluation required by Rule 13a-15 under the Exchange Act, under the leadership and with the participation of our President and Chief Executive Officer (“CEO”) and Chief Financial Officer (“CFO”), of the effectiveness of our disclosure controls and procedures as defined in Rule 13a-15 under the Exchange Act (“Disclosure Controls”). Based on the evaluation, our CEO and CFO concluded that our Disclosure Controls were effective as of the end of the period covered by this Quarterly Report.

***Changes in Internal Control Over Financial Reporting***

There has not been any change in our internal control over financial reporting (as defined in Rule 13a-15(f) of the Exchange Act) identified in connection with the evaluation required by Rule 13a-15(d) under the Exchange Act during the quarter ended June 30, 2010 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

## Part II – OTHER INFORMATION

### Item 1. Legal Proceedings.

Information relating to legal proceedings, including a description of the status of ongoing investigations, actions and lawsuits arising from, or consequential to, these investigations is discussed in our 2009 Form 10-K and our Form 10-Q for first quarter 2010. Set forth below are the material developments that occurred since the filing date of our first quarter 2010 Form 10-Q.

#### *Government Investigations*

On June 24, 2010, (i) the United States government filed its Notice of Election to Intervene in three of the *qui tam* matters, and (ii) we announced that we reached a preliminary agreement (the “Preliminary Settlement”) with the Civil Division of the United States Department of Justice (the “Civil Division”), the Civil Division of the United States Attorney’s Office for the Middle District of Florida (the “USAO”), and the Civil Division of the United States Attorney’s Office for the District of Connecticut to settle their pending inquiries. On June 25, 2010 the United States District Court for the Middle District of Florida (the “Federal Court”) lifted the seal in three of the *qui tam* complaints and those complaints are now publicly available. The Preliminary Settlement is subject to completion and approval of an executed written settlement agreement and other government approvals. If any party objects to the Preliminary Settlement, the Federal Court will conduct a hearing to determine whether the proposed settlement is fair, adequate and reasonable under all the circumstances. Upon execution of the settlement agreement, we would, among other things, agree to pay the Civil Division a total of \$137.5 million (the “Settlement Amount”), for which the first installment will be due after a written settlement agreement has been executed and the following three installments will be paid over a period of up to 36 months after the date of that executed written settlement agreement (the “Payment Period”) plus interest at the rate of 3.125% per year. The Preliminary Settlement includes an acceleration clause that would require immediate payment of the remaining balance of the Settlement Amount in the event that we were acquired or otherwise experienced a change in control during the Payment Period. In addition, the Preliminary Settlement provides for a contingent payment of an additional \$35.0 million in the event that we are acquired or otherwise experiences a change in control within three years of the execution of the settlement agreement and provided that the change in control transaction exceeds certain minimum transaction value thresholds to be specified in the settlement agreement. We expect that the final settlement agreement will provide that the Settlement Amount will include approximately \$22.9 million owed to the Florida Agency for Health Care Administration (“AHCA”) as a result of overpayments received by us from AHCA during the three month period of August 2005 through October 2005. These overpayments were the result of a change implemented by AHCA in the payment methodology relating to medical benefits for newborns. We previously had recorded this liability and had been in discussions with AHCA regarding the reconciliation and repayment of this overpayment. We have discounted the total liability of \$137.5 million for the resolution of these matters and accrued this amount at its estimated fair value of \$134.0 million as of June 30, 2010. There can be no assurance that the Preliminary Settlement will be finalized and approved and the actual outcome of these matters may differ materially from the terms of the Preliminary Settlement.

#### *Putative Class Action Complaints*

In April 2010, the Lead Plaintiffs in the putative class action complaints filed against us in 2007 entitled *Eastwood Enterprises, L.L.C. v. Farha, et al.* and *Hutton v. WellCare Health Plans, Inc. et al.*, filed their motion for class certification. On June 18, 2010, the USAO filed motions seeking to intervene and for a temporary stay of discovery of this matter. In July 2010, the Federal Court granted the United States’ motions and ordered that discovery be stayed until December 2010.

On August 6, 2010, we reached agreement with the Lead Plaintiffs on the material terms of a settlement to resolve this matter. The terms of the settlement will be documented in a formal settlement agreement which will require approval by the Federal Court following notice to all class members. The settlement provides that we will make cash payments to the class of \$52.5 million within thirty business days following the Federal Court’s preliminary approval of the settlement and \$35.0 million by July 31, 2011. The settlement also provides that we will issue to the class tradable unsecured bonds having an aggregate face value of \$112.5 million, with a fixed coupon of 6% and a maturity date of December 31, 2016. The bonds shall also provide that, if we incur debt obligations in excess of \$425.0 million that are senior to the bonds, the bonds shall accelerate as to payment and be redeemed. The settlement has two further contingencies. First, it provides that if, within three years following the date of the settlement agreement, the Company is acquired or otherwise experiences a change in control at a share price of \$30.00 or more, we will pay to the class an additional \$25.0 million. Second, the settlement provides that we will pay to the class 25% of any sums we recover from Messrs. Farha, Behrens and/or Bereday as a result of claims arising from the same facts and circumstances that gave rise to this matter. We may terminate the settlement if a certain number or percentage of the class opt out of the settlement class. The settlement agreement will also provide that the settlement does not constitute an admission of liability by any party and such other terms as are customarily contained in settlement agreements of similar matters.

As a result of this settlement having been reached, our current estimate for the resolution of this matter is \$200.0 million. We have discounted the \$200.0 million liability for the resolution of this matter and accrued this amount at its estimated fair value, which amounted to approximately \$193.9 million at June 30, 2010. There can be no assurance that the settlement will be finalized and approved and the actual outcome of this matter may differ materially from the terms of the settlement.



### ***Derivative Lawsuits***

As previously disclosed, in March 2010, a Stipulation of Partial Settlement (“Stipulation I”) was filed in the Federal Court in the pending derivative action. Under the terms of Stipulation I, the plaintiffs in the federal action have agreed that the Special Litigation Committee's motion to dismiss the director defendants and to realign us as a plaintiff should be granted in its entirety. The plaintiffs in the consolidated federal putative shareholder derivative actions also have agreed to dismiss their claims against Messrs. Farha, Behrens and Bereday. In turn, during the first quarter of 2010, we paid to plaintiffs' counsel in the federal action attorneys' fees in the amount of \$1.7 million. In April 2010, the Federal Court entered an order preliminarily approving Stipulation I and directing us to provide notice to our shareholders. The Federal Court approved Stipulation I and granted our motion to dismiss the director defendants and realigned us as the plaintiff in this action in July 2010. The case is now styled as *WellCare v. Farha, et al.* In July 2010, the Federal Court stayed discovery until December 2010.

In April 2010, a second Stipulation of Partial Settlement (“Stipulation II”) was filed in the Circuit Court for Hillsborough County, Florida (the “State Court”) in the pending derivative action. Under the terms of Stipulation II, the plaintiffs in the state action have agreed that the Special Litigation Committee's motion to dismiss the director defendants and to realign us as a plaintiff should be granted in its entirety. In turn, during the first quarter of 2010, we paid to plaintiffs' counsel in the state action attorneys' fees in the amount of approximately \$0.6 million. The State Court approved Stipulation II and granted our motion to dismiss the director defendants and realigned us as the plaintiff in this action in June 2010. In July 2010, Mr. Farha filed a Notice of Appeal in this matter.

### ***Other Lawsuits and Claims***

We have reached an agreement in principle to resolve the previously disclosed matter filed against us in the Court of Chancery of the State of Delaware entitled *Behrens, et al. v. WellCare Health Plans, Inc.* and we will continue to pay their respective expenses, including attorney fees, under certain terms, in connection with the investigations and litigation.

### **Item 1A. Risk Factors.**

Set forth below is a material update to the risk factors disclosed in “Part I – Item 1A – Risk Factors” of our 2009 Form 10-K.

### **Recently enacted health legislation is expected to bring about significant reform to the American health care system; and present challenges for our business that could have a material adverse effect on our results of operations and cash flows.**

In March 2010, President Obama signed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the “2010 Acts”). We believe these laws will bring about significant changes to the American health care system. These laws are intended to expand the number of United States citizens covered by health insurance over time by increasing the eligibility thresholds for most state Medicaid programs and make other coverage, delivery, and payment changes to the current health care system. Health care reform is expected to trigger transformation and disruption across the industry. Most major provisions become effective in 2014; however some, such as changes to Medicare Advantage (“MA”) election periods, are effective sooner.

The costs of implementing the 2010 Acts will be financed, in part, by future reductions in the payments made to Medicare providers. Furthermore, the 2010 Acts contain other provisions that may adversely affect our profitability, including a phased reduction of MA rates, MA payments tied to quality scores, minimum loss ratios for MA plans effective in 2014 and imposition of an annual fee on the health insurance sector that will be allocated across the industry according to each company's respective market share compared to the overall industry, effective in 2014. Any of the aforementioned revisions to the existing system may adversely impact our results of operations and cash flows. Additionally, our efforts to implement these revisions may detract us from carrying out our strategic priorities and may burden our operational capacity and available capital, and could have an adverse effect on our business.

## [Table of Contents](#)

The 2010 Acts include a number of changes to the way MA plans will be compensated in the future. Beginning in 2012, MA plan premiums will be tied to quality measures and based on a CMS “5-star rating system.” This rating system allows an MA plan to receive an increase in certain premium rates. It is unknown whether these ratings will be geographically or demographically adjusted. The final methodology used in the determination of our quality score, which continues to be developed by CMS, could impact our ability to provide additional benefits and entice new members.

In 2009, as part of the American Recovery and Reinvestment Act, Congress increased the Federal Medical Assistance Percentages (“FMAP”), temporarily increasing federal funding for state Medicaid programs. The policy rationale was to help relieve states’ fiscal problems in the face of declining revenues and rising Medicaid enrollments due to the economic downturn. The enhanced FMAP is set to expire at the end of 2010. The Senate and House of Representatives have separately passed legislation extending additional enhanced FMAP funding through June 2011. While we anticipate Congress will reach consensus prior to the end of the calendar year, some states may realize less federal revenue than expected. State budget shortfalls could result in program cuts, which could impact our premium or membership.

Currently, we anticipate that the 2010 Acts could significantly increase the number of citizens who are eligible to enroll in our Medicaid products. Accordingly, we will need to evaluate our capability to absorb the potential increase in demand from the newly-insured. Regardless, state budgets continue to be strained due to economic conditions and uncertain levels of federal financing for current populations. Additionally, many of the provisions of the 2010 Acts will be implemented through regulations that have yet to be adopted. As a result, the effects of any potential future expansions could result in lower payment rates, making it difficult to determine whether the 2010 Acts will have a positive or negative impact on our business.

### **Item 2. Unregistered Sales of Equity Securities and Use of Proceeds.**

#### *Recent Sales of Unregistered Securities*

We did not sell any securities in the three months ended June 30, 2010 that were not registered under the Securities Act of 1933, as amended.

#### *Issuer Purchases of Equity Securities*

We do not have a stock repurchase program. However, during the quarter ended June 30, 2010, certain of our employees were deemed to have surrendered shares of our common stock to satisfy their withholding tax obligations associated with the vesting of shares of restricted common stock. The following table summarizes these repurchases:

| <b>Period</b>                            | <b>Total Number of Shares Purchased(1)</b> | <b>Average Price Paid Per Share(1)</b> | <b>Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs</b> | <b>Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs</b> |
|--|--|--|---|---|
| April 1, 2010 through April 30, 2010     | 447  | \$ 29.28 (2)                           | N/A   | N/A   |
| May 1, 2010 through May 31, 2010         | 281  | \$ 26.86 (3)                           | N/A   | N/A   |
| June 1, 2010 through June 30, 2010       | 588  | \$ 27.74 (4)                           | N/A   | N/A   |
| Total during quarter ended June 30, 2010 | 1,316                                      | \$ 27.92 (5)                           | N/A   | N/A   |

- (1) The number of shares purchased represents the number of shares of our common stock deemed surrendered by our employees to satisfy their withholding tax obligations due to the vesting of shares of restricted common stock. For the purposes of this table, we determined the average price paid per share based on the closing price of our common stock as of the date of the determination of the withholding tax amounts (i.e., the date that the shares of restricted stock vested). We do not currently have a stock repurchase program. We did not pay any cash consideration to repurchase these shares.
- (2) The weighted average price paid per share during the period was \$29.23.
- (3) The weighted average price paid per share during the period was \$26.79.
- (4) The weighted average price paid per share during the period was \$27.67.
- (5) The weighted average price paid per share during the period was \$27.72.

## Item 5. Other Information.

### *Georgia Department of Community Health*

As previously disclosed, in 2008 the Georgia Department of Community Health (“DCH”) engaged a third party to conduct an audit and reconciliation of our encounter submissions to determine our then current and ongoing level of compliance with contractual encounter submission requirements. At the request of DCH, we would like to disclose that it was DCH that first identified our failure to submit encounter data as required. We then performed our own internal audit procedures once alerted to this issue. The description in this Form 10-Q supersedes and supplements the description included in the Form 8-K we filed with the SEC on April 23, 2010, to the extent inconsistent therewith. We continue to review our payment and data collection methods to improve the accuracy and completeness of our encounter data. Please refer to Item 1A “Risk Factors – Risks Related to Our Business” in our 2009 Form 10-K for further information.

### *Relocation Policy*

On August 4, 2010, our Compensation Committee approved a relocation assistance program for our executive officers. The benefits include financial assistance in selling the executive’s current home and purchasing a new home, as well as moving expenses and tax assistance with respect to certain relocation benefits that are includable in gross income. The benefits are provided pursuant to the Company’s relocation program, a summary of which is attached hereto as Exhibit 10.13.

### *Indemnification Agreement Amendment*

As previously disclosed, on May 8, 2009, the Board approved a form of indemnification agreement (the “2009 Indemnification Agreement”) to be entered into by the Company and (i) each member of the Board and (ii) each member of the Company’s Disclosure Committee (each such executing individual, an “Indemnitee”). The terms of the 2009 Indemnification Agreement were described in the Company’s Current Report on Form 8-K filed with the SEC on May 14, 2009. On August 5, 2010, the Board approved a new form of indemnification agreement (the “2010 Indemnification Agreement”) which is similar to the 2009 Indemnification Agreement except as follows:

- Section 1(e) has been amended to provide that the Company may place reasonable terms and conditions on the advancement of expenses to the Indemnitee.
- Section 2(b) has been amended to require the Indemnitee to provide all information and cooperation as the Company reasonably requires in connection with the advancement of expenses.
- Section 7 has been amended to require the Company to use best efforts to obtain and maintain liability insurance for directors and officers in reasonable amounts from reputable insurers.

The foregoing description does not purport to be a complete description of the 2010 Indemnification Agreement. The foregoing description is qualified in its entirety by reference to the 2010 Indemnification Agreement, the form of which is attached hereto as Exhibit 10.8.

The Company intends to enter into an agreement with each Indemnitee (including all of our directors and executive officers) in the form of the 2010 Indemnification Agreement. By its terms, the 2010 Indemnification Agreement becomes effective upon execution and governs the indemnification rights and obligations of the Indemnitee and the Company with respect to Proceedings (as defined in the 2010 Indemnification Agreement) that arose or may arise from actual or alleged events, occurrences, acts or omissions occurring after the effective date. To the extent that an Indemnitee has previously executed an indemnification agreement with the Company that remains in full force and effect, that previous indemnification agreement will govern the indemnification rights and obligations of the Indemnitee and the Company with respect to Proceedings that arose or may arise from actual or alleged events, occurrences, acts or omissions occurring prior to the effective date of the 2010 Indemnification Agreement. This includes any agreement in the form of the 2009 Indemnification Agreement and/or the form of indemnification agreement attached as Exhibit 10.24 to the Company’s amended Registration Statement on Form S-1 filed with the SEC on June 8, 2004.

**Item 6. Exhibits.**

Exhibits are incorporated herein by reference or are filed or furnished with this report as set forth in the Exhibit Index on page 39 hereof.

## SIGNATURES

Pursuant to the requirements of the Securities and Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized in Tampa, Florida on August 9, 2010.

WELLCARE HEALTH PLANS, INC.

By: /s/ Thomas L. Tran  
Thomas L. Tran  
Senior Vice President and Chief Financial Officer (Principal Financial Officer)

By: /s/ Maurice S. Hebert  
Maurice S. Hebert  
Chief Accounting Officer (Principal Accounting Officer)

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## **FORM 10-Q**

**WELLCARE HEALTH PLANS, INC. - WCG**

**Filed: November 04, 2010 (period: September 30, 2010)**

Quarterly report which provides a continuing view of a company's financial position

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**UNITED STATES**  
**SECURITIES AND EXCHANGE COMMISSION**  
Washington, D.C. 20549  
**FORM 10-Q**

(Mark One)

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

For the quarterly period ended **September 30, 2010**  
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: **001-32209**

**WELLCARE HEALTH PLANS, INC.**

(Exact name of registrant as specified in its charter)

**Delaware**

(State or other jurisdiction of  
incorporation or organization)

**47-0937650**

(I.R.S. Employer  
Identification No.)

**8725 Henderson Road, Renaissance One  
Tampa, Florida**

(Address of principal executive offices)

**33634**

(Zip Code)

**(813) 290-6200**

(Registrant's telephone number, including area code)

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.

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 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 "smaller reporting company" in Rule 12b-2 of the Exchange Act

Large Accelerated Filer  Accelerated Filer  Non-Accelerated Filer

Smaller Reporting Company  (Do not check if a 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

As of November 1, 2010 there were 42,537,445 shares of the registrant's common stock, par value \$.01 per share, outstanding.

WELLCARE HEALTH PLANS, INC.

TABLE OF CONTENTS

|                                       | <u>Page</u>   |
|---------------------------------------|---|
| <b>Part I — FINANCIAL INFORMATION</b> |   |
| Item 1.                               | Financial Statements  |
|                                       | Condensed Consolidated Balance Sheets at September 30, 2010 (unaudited) and December 31, 2009                               |
|                                       | 3   |
|                                       | Condensed Consolidated Statements of Operations for the three and nine months ended September 30, 2010 and 2009 (unaudited) |
|                                       | 4   |
|                                       | Condensed Consolidated Statements of Cash Flows for the nine months ended September 30, 2010 and 2009 (unaudited)           |
|                                       | 5   |
|                                       | Notes to Condensed Consolidated Financial Statements  |
|                                       | 6   |
| Item 2.                               | Management's Discussion and Analysis of Financial Condition and Results of Operations                                       |
|                                       | 19  |
| Item 3.                               | Quantitative and Qualitative Disclosures About Market Risk  |
|                                       | 34  |
| Item 4.                               | Controls and Procedures   |
|                                       | 35  |
| <b>Part II — OTHER INFORMATION</b>    |   |
| Item 1.                               | Legal Proceedings   |
|                                       | 36  |
| Item 1A.                              | Risk Factors  |
|                                       | 37  |
| Item 2.                               | Unregistered Sales of Equity Securities and Use of Proceeds   |
|                                       | 38  |
| Item 6.                               | Exhibits  |
|                                       | 38  |
|                                       | Signatures  |

**Part I — FINANCIAL INFORMATION**

**Item 1. Financial Statements.**

**WELLCARE HEALTH PLANS, INC.  
CONDENSED CONSOLIDATED BALANCE SHEETS  
(In thousands, except share data)**

|  | <b>September 30,<br/>2010</b> | <b>December 31,<br/>2009</b> |
|--|-------------------------------|------------------------------|
|  | <u>(Unaudited)</u>            |                              |
| <b>Assets</b>  |                               |                              |
| Current Assets:  |                               |                              |
|  | \$                            | \$                           |
| Cash and cash equivalents  | 1,091,015                     | 1,158,131                    |
| Investments  | 72,709                        | 62,722                       |
| Premium and other receivables, net   | 309,998                       | 285,808                      |
| Funds receivable for the benefit of members  | 55,262                        | 77,851                       |
| Prepaid expenses and other current assets, net   | 121,106                       | 104,079                      |
| Deferred income tax asset  | 56,638                        | 28,874                       |
| Total current assets   | <u>1,706,728</u>              | <u>1,717,465</u>             |
| Property, equipment and capitalized software, net  | 68,534                        | 61,785                       |
| Goodwill   | 111,131                       | 111,131                      |
| Other intangible assets, net   | 11,811                        | 12,961                       |
| Long-term investments  | 46,838                        | 51,710                       |
| Restricted investments   | 124,694                       | 130,550                      |
| Deferred income tax asset  | 69,277                        | 29,654                       |
| Other assets   | 4,118                         | 3,191                        |
|  | <u>\$ 2,143,131</u>           | <u>\$ 2,118,447</u>          |
| <b>Liabilities and Stockholders' Equity</b>  |                               |                              |
| Current Liabilities:   |                               |                              |
|  | \$                            | \$                           |
| Medical benefits payable   | 703,664                       | 802,515                      |
| Unearned premiums  | 65,992                        | 90,496                       |
| Accounts payable   | 8,869                         | 5,270                        |
| Other accrued expenses and liabilities   | 150,834                       | 220,562                      |
| Current portion of amounts accrued related to investigation resolution   | 117,601                       | 18,192                       |
| Other payables to government partners  | 42,447                        | 38,147                       |
| Income taxes payable   | 18,362                        | 4,888                        |
| Total current liabilities  | <u>1,107,769</u>              | <u>1,180,070</u>             |
| Amounts accrued related to investigation resolution  | 213,649                       | 40,205                       |
| Other liabilities  | 19,677                        | 17,272                       |
| Total liabilities  | <u>1,341,095</u>              | <u>1,237,547</u>             |
| Commitments and contingencies (see Note 7)   | -                             | -                            |
| Stockholders' Equity:  |                               |                              |
| Preferred stock, \$0.01 par value (20,000,000 authorized, no shares issued or outstanding)   | -                             | -                            |
| Common stock, \$0.01 par value (100,000,000 authorized, 42,538,975 and 42,361,207 shares issued and outstanding at September 30, 2010 and December 31, 2009, respectively) | 425                           | 424                          |
| Paid-in capital  | 424,529                       | 425,083                      |
| Retained earnings  | 378,975                       | 458,512                      |
| Accumulated other comprehensive loss   | (1,893)                       | (3,119)                      |
| Total stockholders' equity   | <u>802,036</u>                | <u>880,900</u>               |
|  | \$                            | \$                           |
| Total Liabilities and Stockholders' Equity   | <u>2,143,131</u>              | <u>2,118,447</u>             |

*See notes to unaudited condensed consolidated financial statements.*

**WELLCARE HEALTH PLANS, INC.**  
**CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS**  
(Unaudited, in thousands, except per share data)

|  | Three Months Ended<br>September 30, |                  | Nine Months Ended<br>September 30, |                  |
|--|-------------------------------------|------------------|------------------------------------|------------------|
|  | 2010                                | 2009             | 2010                               | 2009             |
| Revenues:  |                                     |                  |                                    |                  |
| Premium  | \$ 1,385,874                        | \$ 1,666,031     | \$ 4,077,269                       | \$ 5,245,809     |
| Investment and other income                      | 2,299                               | 1,614            | 7,506                              | 8,375            |
| Total revenues                                   | <u>1,388,173</u>                    | <u>1,667,645</u> | <u>4,084,775</u>                   | <u>5,254,184</u> |
| Expenses:  |                                     |                  |                                    |                  |
| Medical benefits                                 | 1,147,107                           | 1,420,193        | 3,435,870                          | 4,477,210        |
| Selling, general and administrative              | 161,662                             | 195,665          | 739,769                            | 682,488          |
| Depreciation and amortization                    | 6,123                               | 5,851            | 17,770                             | 17,547           |
| Interest   | 117                                 | 4                | 160                                | 3,087            |
| Total expenses                                   | <u>1,315,009</u>                    | <u>1,621,713</u> | <u>4,193,569</u>                   | <u>5,180,332</u> |
| Income (loss) before income taxes                | 73,164                              | 45,932           | (108,794)                          | 73,852           |
| Income tax expense (benefit)                     | 30,248                              | 17,272           | (29,257)                           | 45,120           |
| Net income (loss)                                | <u>\$ 42,916</u>                    | <u>\$ 28,660</u> | <u>\$ (79,537)</u>                 | <u>\$ 28,732</u> |
| Net income (loss) per common share (see Note 1): |                                     |                  |                                    |                  |
| Basic  | \$ 1.01                             | \$ 0.68          | \$ (1.88)                          | \$ 0.69          |
| Diluted  | \$ 1.00                             | \$ 0.68          | \$ (1.88)                          | \$ 0.68          |

*See notes to unaudited condensed consolidated financial statements.*

**WELLCARE HEALTH PLANS, INC.**  
**CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS**  
(Unaudited, in thousands)

|  | <b>Nine Months Ended September 30,</b> |              |
|--|--|--------------|
|  | <b>2010</b>                            | <b>2009</b>  |
| Cash provided by (used in) operating activities:   |  |              |
| Net (loss) income  | \$ (79,537)                            | \$ 28,732    |
| Adjustments to reconcile net (loss) income to net cash (used in) provided by operating activities: |  |              |
| Depreciation and amortization  | 17,770                                 | 17,547       |
| Equity-based compensation expense  | 8,655                                  | 29,776       |
| Deferred taxes, net  | (67,386)                               | 8,526        |
| Changes in operating accounts:   |  |              |
| Premium and other receivables, net   | (24,190)                               | 10,111       |
| Other receivables from government partners, net  | -                                      | (40,073)     |
| Prepaid expenses and other, net  | (17,027)                               | 15,301       |
| Medical benefits payable   | (98,851)                               | 91,708       |
| Unearned premiums  | (24,504)                               | (60,489)     |
| Accounts payable and other accrued expenses  | (43,635)                               | (64,465)     |
| Other payables to government partners  | 4,300                                  | 18,397       |
| Amounts accrued related to investigation resolution  | 249,915                                | 30,249       |
| Income taxes, net  | 7,594                                  | (5,450)      |
| Other, net   | (5,088)                                | (10,328)     |
| Net cash (used in) provided by operating activities  | (71,984)                               | 69,542       |
| Cash provided by (used in) investing activities:   |  |              |
| Purchases of investments   | (117,903)                              | (19,295)     |
| Proceeds from sales and maturities of investments  | 114,726                                | 34,012       |
| Purchases of restricted investments  | (18,386)                               | (64,039)     |
| Proceeds from maturities of restricted investments   | 24,298                                 | 131,707      |
| Additions to property, equipment and capitalized software, net                                     | (16,192)                               | (9,908)      |
| Net cash (used in) provided by investing activities  | (13,457)                               | 72,477       |
| Cash provided by (used in) financing activities:   |  |              |
| Proceeds from option exercises and other   | 1,091                                  | 418          |
| Purchase of treasury stock   | (4,420)                                | -            |
| Payments on debt   | -                                      | (152,800)    |
| Payments on capital leases   | (935)                                  | -            |
| Funds received (used) for the benefit of members   | 22,589                                 | (341)        |
| Net cash provided by (used in) financing activities  | 18,325                                 | (152,723)    |
| Cash and cash equivalents:   |  |              |
| Decrease during the period   | (67,116)                               | (10,704)     |
| Balance at beginning of year   | 1,158,131                              | 1,181,922    |
| Balance at end of period   | \$ 1,091,015                           | \$ 1,171,218 |
| <b>SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION:</b>  |  |              |
| Cash paid for taxes  | \$ 35,686                              | \$ 58,489    |
| Cash paid for interest   | \$ 183                                 | \$ 2,642     |
| Equipment acquired through capital leases  | \$ 8,868                               | \$ 559       |

*See notes to unaudited condensed consolidated financial statements.*

**WELLCARE HEALTH PLANS, INC.**  
**NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS**  
(Unaudited, in thousands, except member, per share and share data)

**1. ORGANIZATION AND BASIS OF PRESENTATION**

WellCare Health Plans, Inc., a Delaware corporation (the “Company,” “we,” “us,” or “our”), provides managed care services exclusively to government-sponsored health care programs, focusing on Medicaid and Medicare, including health plans for families, children, and the aged, blind and disabled, serving approximately 2,200,000 members as of September 30, 2010. Our Medicaid plans include plans for beneficiaries of Temporary Assistance for Needy Families (“TANF”) programs, Supplemental Security Income (“SSI”) programs, Aged Blind and Disabled (“ABD”) programs and state-based programs that are not part of the Medicaid program, such as Children’s Health Insurance Programs (“CHIP”) and Family Health Plus (“FHP”) programs. TANF generally provides assistance to low-income families with children. ABD and SSI generally provide assistance to low-income aged, blind or disabled individuals. CHIP and FHP generally provide assistance for qualifying families who are not eligible for Medicaid because they exceed the applicable income thresholds. Through our licensed subsidiaries, as of September 30, 2010, we operated our Medicaid health plans in Florida, Georgia, Hawaii, Illinois, Missouri, New York and Ohio. Our Medicare plans include stand-alone prescription drug plans (“PDPs”) in our PDP segment and Medicare Advantage (“MA”) plans in our MA segment, which, following our exit of the Medicare private fee-for-service (“PFFS”) program on December 31, 2009, is comprised of Medicare coordinated care plans (“CCPs”). As of September 30, 2010, we offered our CCPs in Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Louisiana, Missouri, New Jersey, New York, Ohio and Texas, and our PDPs in 49 states and the District of Columbia.

***Basis of Presentation***

The accompanying unaudited condensed consolidated interim financial statements should be read in conjunction with the consolidated financial statements and notes thereto for the fiscal year ended December 31, 2009 included in our Annual Report on Form 10-K (“2009 Form 10-K”), filed with the United States Securities and Exchange Commission (the “SEC”) in February 2010. In the opinion of management, the interim financial statements reflect all normal recurring adjustments that we consider necessary for the fair presentation of our financial position, results of operations and cash flows for the interim periods presented. The interim financial statements included herein have been prepared in accordance with accounting principles generally accepted in the United States of America (“GAAP”) and with the instructions to Form 10-Q and Article 10 of Regulation S-X. Accordingly, certain information and footnote disclosures normally included in financial statements prepared in accordance with GAAP have been condensed or omitted. Results for the interim periods presented are not necessarily indicative of results that may be expected for the entire year or any other interim period. Certain items in our financial statements have been reclassified from their prior year classifications to conform to our current year presentation. We have evaluated all material events subsequent to the date of these financial statements.

***Net Income (Loss) per Share***

We compute basic net income (loss) per common share on the basis of the weighted-average number of unrestricted common shares outstanding. Diluted net income per common share is computed on the basis of the weighted-average number of unrestricted common shares outstanding plus the dilutive effect of outstanding stock options, restricted shares, restricted stock units and performance stock units using the treasury stock method. The following table presents the calculation of net income (loss) per common share — basic and diluted:

|   | <b>Three Months Ended</b> |             | <b>Nine Months Ended</b> |             |
|---|---------------------------|-------------|--------------------------|-------------|
|   | <b>September 30,</b>      |             | <b>September 30,</b>     |             |
|   | <b>2010</b>               | <b>2009</b> | <b>2010</b>              | <b>2009</b> |
| <b>Numerator:</b>   |                           |             |                          |             |
| Net income (loss)   | \$ 42,916                 | \$ 28,660   | \$ (79,537)              | \$ 28,732   |
| <b>Denominator:</b>   |                           |             |                          |             |
| Weighted-average common shares outstanding — basic                            | 42,411,455                | 41,849,749  | 42,313,973               | 41,771,713  |
| Dilutive effect of:   |                           |             |                          |             |
| Unvested restricted stock, restricted stock units and performance stock units | 244,024                   | 348,539     | -                        | 175,149     |
| Stock options   | 84,890                    | 81,747      | -                        | 60,440      |
| Weighted-average common shares outstanding — diluted                          | 42,740,369                | 42,280,035  | 42,313,973               | 42,007,302  |
| Net income (loss) per common share:   |                           |             |                          |             |
| Basic   | \$ 1.01                   | \$ 0.68     | \$ (1.88)                | \$ 0.69     |
| Diluted   | \$ 1.00                   | \$ 0.68     | \$ (1.88)                | \$ 0.68     |

For the three months ended September 30, 2010 as well as the three and nine months ended September 30, 2009, certain options to purchase common stock were not included in the calculation of diluted net income per common share because their exercise prices were greater than the average market price of our common stock for the period and, therefore, the effect would be anti-dilutive. For the three months ended September 30, 2010, 102,000 restricted equity awards and 971,121 options with exercise prices ranging from \$19.38 to \$91.64 were excluded from diluted weighted-average common shares outstanding. For the three and nine months ended September 30, 2009, 1,200,422 and 1,580,570 restricted equity awards, respectively, and 2,133,215 options with exercise prices ranging from \$19.38 to \$105.37 and 2,212,824 options with exercise prices ranging from \$13.13 to \$105.37, respectively, were excluded from diluted weighted-average common shares outstanding. Due to the net loss for the nine months ended September 30, 2010, the assumed exercise of 2,444,257 equity awards had an anti-dilutive effect and was therefore excluded from the computation of diluted loss per share.

## **Revenue Recognition**

Our Medicaid contracts with state governments are generally multi-year contracts subject to annual renewal provisions. Our Medicare Advantage and PDP contracts with the Centers for Medicare & Medicaid Services (“CMS”) generally have terms of one year. In most cases we receive premiums in advance of providing services, and we recognize premium revenue during the period in which we are obligated to provide services to our members. We estimate, on an ongoing basis, the amount of member and state billings that may not be fully collectible. CMS and certain states employ a risk-adjustment model to the premiums we receive whereby the ultimate premium earned is based on the beneficiaries’ health status or the attainment of a specified medical benefits ratio (“MBR”) for the population during the contract term. Our MBR represents the ratio of our medical benefits expense to premiums earned. We estimate the amount of premium that would be returned, if any, based on historical trends, anticipated and actual MBRs and other factors. An allowance is established for the estimated amount of premiums that may not be collectible and a liability is established for premiums expected to be returned. The allowance has not been significant to premium revenue. The payment we receive monthly from CMS for our PDP program generally represents our bid amount for providing prescription drug insurance coverage. We recognize premium revenue for providing this insurance coverage ratably over the term of our annual contract. Premiums collected in advance of the period in which we are obligated to provide services to our members are deferred and reported as Unearned premiums in the accompanying Condensed Consolidated Balance Sheets and amounts that have not been received by the end of the period remain on the Condensed Consolidated Balance Sheets classified as Premium and other receivables.

Premium payments that we receive are based upon eligibility lists produced by the government. We verify these lists to determine whether we have been paid for the correct premium category and program. From time to time, the states or CMS require us to reimburse them for premiums that we received based on an eligibility list that a state, CMS or we later discover contains individuals who were not eligible for any government-sponsored program or belong to a different plan other than ours. The verification and subsequent membership changes may result in additional amounts due to us or we may owe premiums back to the government. The amounts receivable or payable identified by us through reconciliation and verification of agency eligibility lists relate to current and prior periods. The amounts receivable from government agencies for reconciling items were \$26,289 and \$64,311 at September 30, 2010 and December 31, 2009, respectively, and are included in Premium and other receivables on our Condensed Consolidated Balance Sheets. The amounts due to government agencies for reconciling items were \$43,697 and \$105,143 at September 30, 2010 and December 31, 2009, respectively, and are included in Other accrued expenses and liabilities on our Condensed Consolidated Balance Sheets. We record adjustments to revenues based on member retroactivity. These adjustments reflect changes in the number and eligibility status of enrollees subsequent to when revenue was billed. We estimate the amount of outstanding retroactivity adjustments each period and adjust premium revenue accordingly; if appropriate, the estimates of retroactivity adjustments are based on historical trends, premiums billed, the volume of member and contract renewal activity and other information. Changes in member retroactivity adjustment estimates had a minimal impact on premiums recorded during the periods presented. Our government contracts establish monthly rates per member that may be adjusted based on member demographics such as age, working status or medical history.

### ***Premium Taxes Remitted to Governmental Authorities***

Certain state agencies place an assessment or tax on premiums (“Premium taxes”), which are remitted to us in the premium rates we receive and recorded as a component of revenue as well as administrative expense when incurred. In October 2009, the state of Georgia stopped assessing taxes on Medicaid premiums remitted to us, which resulted in an equal reduction to Premium revenues and Selling, general and administrative expenses. However, effective July 1, 2010, the state of Georgia began assessing Premium taxes again on Medicaid premiums. During the three and nine months ended September 30, 2010, we were assessed and remitted taxes on premiums in Georgia, Hawaii, Missouri, New York and Ohio. Premium taxes for the three and nine months ended September 30, 2010 were \$18,950 and \$38,078, respectively. For the three and nine months ended September 30, 2009, Premium taxes were \$26,790 and \$80,112, respectively.

### ***Goodwill and Intangible Assets***

Our annual impairment test was performed as of the second quarter of 2010 and completed during the third quarter of 2010. We assessed the book value of goodwill and other intangible assets using both the income and market approach, which utilizes certain assumptions and estimates, such as the discount factor and peer benchmarking, respectively, in estimating fair values. We have determined that the fair value of our goodwill exceeds its carrying value, and as a result, there were no indications of additional impairment testing required as of September 30, 2010.

### ***Recently Issued Accounting Standards***

In February 2010, the Financial Accounting Standards Board (the “FASB”) issued authoritative guidance related to subsequent events. This standard updates subsequent event guidance, issued in May 2009, requiring reporting entities to provide the date through which subsequent event reviews occurred, which was in conflict with certain SEC requirements. Accordingly, the update to previously issued subsequent event guidance removes the requirement to disclose a date through which subsequent events have been evaluated. The adoption of this guidance did not have a material effect on our financial statements.

In January 2010, the FASB issued authoritative guidance related to improving disclosures about fair value measurements. This standard requires reporting entities to make new disclosures about recurring or nonrecurring fair-value measurements including significant transfers into and out of Level 1 and Level 2 fair value measurements and information on purchases, sales, issuances and settlements on a gross basis in the reconciliation of Level 3 fair value measurements. This standard is effective for annual reporting periods beginning after December 15, 2009, except for Level 3 reconciliation disclosures which are effective for annual periods beginning after December 15, 2010. The adoption of this guidance did not have a material effect on our financial statements.

## **2. SEGMENT REPORTING**

Reportable operating segments are defined as components of an enterprise for which discrete financial information is available and evaluated on a regular basis by the chief operating decision-maker to determine how resources should be allocated to an individual segment and to assess performance of those segments. Previously, we reported two operating segments, Medicaid and Medicare, which coincide with our two main business lines. During the first quarter of 2010, we reassessed our segment reporting practices and made revisions to reflect our current method of managing performance and determining resource allocation, which includes reviewing the results of our PDP operations separately from other Medicare products. Accordingly, we now have three reportable segments within our two main business lines: Medicaid, MA and PDP. The PFFS product that we exited December 31, 2009 is reported within the MA segment. The prior periods have been revised to reflect this segment presentation. Medicaid was established to provide medical assistance to low-income and disabled persons. It is state operated and implemented, although it is funded and regulated by both the state and federal governments. Our Medicaid segment includes plans for beneficiaries of TANF, SSI, ABD and state-based programs that are not part of the Medicaid program, such as CHIP and FHP for qualifying families who are not eligible for Medicaid because they exceed the applicable income thresholds. TANF generally provides assistance to low-income families with children; ABD and SSI generally provide assistance to low-income aged, blind or disabled individuals.

Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons with a variety of hospital, medical insurance and prescription drug benefits.

Our MA segment consists of MA plans, which, following our exit from the PFFS product on December 31, 2009, is comprised of CCPs. MA is Medicare's managed care alternative to original Medicare fee-for-service, which provides individuals standard Medicare benefits directly through CMS. CCPs are administered through health maintenance organizations ("HMOs") and generally require members to seek health care services and select a primary care physician from a network of health care providers. In addition, we offer Medicare Part D coverage, which provides prescription drug benefits, as a component of our MA plans.

We offer stand-alone Medicare Part D coverage to Medicare-eligible beneficiaries in our PDP segment. The Medicare Part D prescription drug benefit is supported by risk sharing with the federal government through risk corridors designed to limit the losses and gains of the drug plans and by reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for risk factor payments. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries. The Part D program offers national in-network prescription drug coverage that is subject to limitations in certain circumstances.

Balance sheet, Investment and other income, and Other expense details by segment have not been disclosed, as they are not reported internally by us. A summary of financial information for our reportable operating segments, as well as a reconciliation to Income (loss) before income taxes is presented in the table below.

|                                   | <b>Three Months Ended<br/>September 30,</b> |                  | <b>Nine Months Ended<br/>September 30,</b> |                  |
|-----------------------------------|---|------------------|--|------------------|
|                                   | <b>2010</b>                                 | <b>2009</b>      | <b>2010</b>                                | <b>2009</b>      |
| Premium revenue:                  |   |                  |  |                  |
| Medicaid                          | \$ 854,893                                  | \$ 814,111       | \$ 2,464,624                               | \$ 2,437,048     |
| Medicare Advantage                | 331,338                                     | 660,009          | 1,012,366                                  | 2,142,921        |
| PDP                               | 199,643                                     | 191,911          | 600,279                                    | 665,840          |
| Total premium revenue             | <u>1,385,874</u>                            | <u>1,666,031</u> | <u>4,077,269</u>                           | <u>5,245,809</u> |
| Medical benefits expense:         |   |                  |  |                  |
| Medicaid                          | 743,169                                     | 710,310          | 2,133,225                                  | 2,091,908        |
| Medicare Advantage                | 260,890                                     | 550,130          | 795,906                                    | 1,762,118        |
| PDP                               | 143,048                                     | 159,753          | 506,739                                    | 623,184          |
| Total medical benefits expense    | <u>1,147,107</u>                            | <u>1,420,193</u> | <u>3,435,870</u>                           | <u>4,477,210</u> |
| Gross margin:                     |   |                  |  |                  |
| Medicaid                          | 111,724                                     | 103,801          | 331,399                                    | 345,140          |
| Medicare Advantage                | 70,448                                      | 109,879          | 216,460                                    | 380,803          |
| PDP                               | 56,595                                      | 32,158           | 93,540                                     | 42,656           |
| Total gross margin                | <u>238,767</u>                              | <u>245,838</u>   | <u>641,399</u>                             | <u>768,599</u>   |
| Investment and other income       | 2,299                                       | 1,614            | 7,506                                      | 8,375            |
| Other expenses                    | <u>(167,902)</u>                            | <u>(201,520)</u> | <u>(757,699)</u>                           | <u>(703,122)</u> |
| Income (loss) before income taxes | <u>\$ 73,164</u>                            | <u>\$ 45,932</u> | <u>\$ (108,794)</u>                        | <u>\$ 73,852</u> |

### 3. EQUITY-BASED COMPENSATION

The compensation expense recorded related to our equity-based compensation awards, which correspondingly also increased Paid-in capital, for the three months ended September 30, 2010 and 2009 was \$6,176 and \$10,534, respectively, and \$8,655 and \$29,776 for the nine months ended September 30, 2010 and 2009, respectively.

Equity-based compensation expense is calculated based on awards ultimately expected to vest and has been adjusted to reflect our estimated forfeitures. We derive our forfeiture estimate at the time of grant and continuously reassess this estimate to determine if our assumptions are indicative of actual forfeitures. Our forfeiture rate assumptions vary by equity award type. For stock options issued subsequent to December 31, 2005, we increased our forfeiture rates from 28% to 40% effective June 30, 2010 to reflect actual historical and expected cancellations of unvested options due to a higher than previously estimated level of employee attrition and terminations. The differential in forfeiture rates, when applied retrospectively, resulted in an expense reversal of approximately \$4,955 recorded in the second quarter of 2010 and is included in Equity-based compensation expense for the nine months ended September 30, 2010.

Under the 2004 Equity Incentive Plan, we granted shares to a former executive, the vesting of which and the amount of shares to be awarded was contingent upon achievement of an earnings per share target over three- and five-year performance periods. The earnings per share target for the first performance period was achieved. However, in accordance with the separation agreement between the former executive and us, issuance of those shares was subject to certain conditions that we have determined have not been, and are unlikely to be, met. Accordingly, the previously recorded compensation cost of \$4,683 was reversed during the first quarter of 2010 and is included in Equity-based compensation expense for the nine months ended September 30, 2010.

A summary of our restricted stock, restricted stock unit (“RSU”) and stock option activity for the nine months ended September 30, 2010 is presented in the table below.

|  | <u>Restricted<br/>Stock and<br/>RSU</u> | <u>Weighted<br/>Average<br/>Grant-Date<br/>Fair Value</u> | <u>Options</u>   | <u>Weighted<br/>Average<br/>Exercise Price</u> |
|--|---|---|------------------|--|
| Outstanding as of January 1, 2010                    |   | \$  |                  | \$   |
|  | 1,339,981                               | 29.30   | 1,919,535        | 35.26  |
| Granted  | 233,020                                 | 29.29   | 109,071          | 29.56  |
| Exercised  | -                                       | -   | (64,042)         | 17.98  |
| Vested   | (383,762)                               | 30.47   | -                | -  |
| Forfeited and expired                                | (199,756)                               | 31.47   | (509,790)        | 42.34  |
| Outstanding at September 30, 2010                    | <u>989,483</u>                          | 28.46   | <u>1,454,774</u> | 33.13  |
| Exercisable at September 30, 2010                    |   |   | <u>1,061,104</u> | 35.23  |
| Vested and expected to vest as of September 30, 2010 |   |   | <u>1,316,096</u> | 34.13  |

As of September 30, 2010, there was \$30,435 of unrecognized compensation cost related to non-vested equity-based compensation arrangements that is expected to be recognized over a weighted-average period of 1.7 years.

#### **Performance Stock Units**

During 2010, the Compensation Committee of the Board of Directors awarded 175,389 Performance Stock Unit Awards (the “2010 PSU Awards”) under the 2004 Equity Incentive Plan to certain of our key employees, including executive officers. The 2010 PSU Awards vest in March 2013 and are subject to adjustment in the target range of 0% to 150%, based on the achievement of certain financial and quality-based performance goals set by the Compensation Committee over the performance period and the employee’s continued service through the vest date. The actual number of PSUs that vest will be determined by the Compensation Committee at its sole discretion. As a result of the subjective nature of the PSUs, we have determined that, for accounting purposes, a mutual understanding of the key terms and conditions does not exist; accordingly, these awards do not have an accounting grant date. The 2010 PSU Awards ultimately expected to vest will be recognized as expense over the service period based on estimated progress towards the performance measures, as well as subsequent changes in the market price of our common stock since the awards do not have an accounting grant date. The compensation expense related to our PSUs assumes that targets will be met and was \$448 and \$691 for the three and nine months ended September 30, 2010, respectively. As of September 30, 2010, there was \$2,830 of unrecognized compensation cost related to non-vested PSUs that is expected to be recognized over a weighted-average period of 2.5 years.



#### 4. FAIR VALUE MEASUREMENTS

Fair value measurements apply to all financial assets and financial liabilities that are being measured and reported on a fair value basis. Accounting standards require that fair value measurements be classified and disclosed in one of the following three categories: Level 1, defined as observable inputs such as quoted prices in active markets; Level 2, defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

Our balance sheet includes the following financial instruments: cash and cash equivalents, investments, receivables, accounts payable, medical benefits payable and amounts accrued related to the investigation resolution discussed in Note 7 to these Condensed Consolidated Financial Statements. The carrying amounts of current assets and liabilities approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization.

Our Long-term investments include \$46,150 and \$57,000 of municipal note investments with an auction reset feature ("auction rate securities"), at par value, as of September 30, 2010 and December 31, 2009, respectively. Liquidity for these auction rate securities is typically provided by an auction process which allows holders to sell their notes and resets the applicable interest rate at pre-determined intervals, usually every seven, 14, 28 or 35 days. Auctions for these auction rate securities continued to fail during the nine months ended September 30, 2010. An auction failure means that the parties wishing to sell their securities could not be matched with an adequate volume of buyers. As a result, our ability to liquidate and fully recover the carrying value of our remaining auction rate securities in the near term may be limited or non-existent. However, when there is a failed auction, the indenture governing the security requires the issuer to pay interest at a contractually defined rate that is generally above market rates for other types of similar instruments. We continue to receive interest payments on the auction rate securities we hold. Based on our analysis of anticipated cash flows, we have determined that it is more likely than not that we will be able to hold these securities until maturity or until market stability is restored. Additionally, there are government guarantees or municipal bond insurance in place and we have the ability and the present intent to hold these securities until maturity or market stability is restored. Accordingly, we do not believe our auction rate securities are impaired and as a result, we have not recorded any impairment losses for our auction rate securities. However, as these securities are believed to be in an inactive market, we have estimated the fair value of these securities using a discounted cash flow model and update these estimates on a quarterly basis. Our analysis considered, among other things, the collateralization underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows and the capital adequacy and expected cash flows of the subsidiaries that hold the securities. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties.

Our assets and liabilities measured at fair value on a recurring basis subject to the disclosure requirements of fair value accounting guidance as of September 30, 2010 and December 31, 2009, were as follows:

| Description                         | Fair Value Measurements at September 30, 2010: |   |  |  |
|-------------------------------------|--|---|--|--|
|                                     | September 30,<br>2010                          | Quoted Prices in<br>Active Markets<br>Identical Assets<br>(Level 1) | Significant Other<br>Observable<br>(Level 2) | Significant<br>Unobservable<br>Inputs<br>(Level 3) |
| Investments:                        |  |   |  |  |
| Available-for-sale securities       |  |   |  |  |
| Certificates of deposit             | \$ 40,559                                      | \$ 40,559   | \$ -   | \$ -   |
| Auction rate securities             | 42,742   | -   | -  | 42,742   |
| Corporate debt and other securities | 30,621   | 30,621  | -  | -  |
| Other municipal variable rate bonds | 5,625  | 5,625   | -  | -  |
| Total investments                   | \$ 119,547                                     | \$ 76,805   | \$ -   | \$ 42,742  |
| Restricted investments:             |  |   |  |  |
| Available-for-sale securities       |  |   |  |  |
| Cash and cash equivalents           | \$ 27,571                                      | \$ 27,571   | \$ -   | \$ -   |
| Certificates of deposit             | 1,053  | 1,053   | -  | -  |
| U.S. Government securities          | 22,294   | 22,294  | -  | -  |
| Money market funds                  | 73,776   | 73,776  | -  | -  |

|  |    |         |    |         |    |   |
|--|----|---------|----|---------|----|---|
| Total restricted investments                           | \$ | 124,694 | \$ | 124,694 | \$ | - |
| <hr/>  |    |         |    |         |    |   |
| Amounts accrued related to investigation resolution(1) | \$ | 331,250 | \$ | 331,250 | \$ | - |
| <hr/>  |    |         |    |         |    |   |

(1) This amount is included in the short- and long-term portions of Amounts accrued related to investigation resolution line items in our Condensed Consolidated Balance Sheets as of September 30, 2010.

| Description   | Fair Value Measurements at December 31, 2009: |   |  |  |
|---|---|---|--|--|
|   | December 31,<br>2009                          | Quoted Prices in<br>Active Markets<br>Identical Assets<br>(Level 1) | Significant Other<br>Observable<br>(Level 2) | Significant<br>Unobservable<br>Inputs<br>(Level 3) |
| Investments:  |   |   |  |  |
| Available-for-sale securities                             |   |   |  |  |
|   | \$  | \$  | \$   | \$   |
| Certificates of deposit                                   | 58,907  | 58,907  | -  | -  |
| Auction rate securities                                   | 51,710  | -   | -  | 51,710   |
| Other municipal variable rate bonds                       | 3,815   | 3,815   | -  | -  |
|   | \$  | \$  | \$   | \$   |
| Total investments   | 114,432                                       | 62,722  | -  | 51,710   |
| Restricted investments:                                   |   |   |  |  |
| Available-for-sale securities                             |   |   |  |  |
|   | \$  | \$  | \$   | \$   |
| Cash and cash equivalents                                 | 4,651   | 4,651   | -  | -  |
| Certificates of deposit                                   | 1,051   | 1,051   | -  | -  |
| U.S. Government securities                                | 20,975  | 20,975  | -  | -  |
| Money market funds  | 103,873                                       | 103,873   | -  | -  |
|   | \$  | \$  | \$   | \$   |
| Total restricted investments                              | 130,550                                       | 130,550   | -  | -  |
|   |   | \$  |  |  |
| Amounts accrued related to investigation<br>resolution(1) | \$ 58,397                                     | -   | \$ 58,397                                    | -  |

(1) This amount is included in the short- and long-term portions of Amounts accrued related to investigation resolution line items in our Condensed Consolidated Balance Sheets as of December 31, 2009.

The following tables present our auction rate securities measured at fair value on a recurring basis using significant unobservable inputs (i.e., Level 3 data) for the three and nine months ended September 30, 2010 and September 30, 2009.

|  | Fair Value Measurements<br>Using Significant<br>Unobservable Inputs<br>(Level 3) |   |
|--|--|---|
|  | Three Months Ended<br>September 30, 2010   | Nine Months Ended<br>September 30, 2010 |
|  | \$   | \$                                      |
| Beginning balance  | 42,477   | 51,710                                  |
| Realized gains (losses) in earnings (or changes in net assets) | -  | -                                       |
| Unrealized gains (losses) in other comprehensive income(a)     | 265  | 1,882                                   |
| Purchases, issuances and settlements                           | -  | -                                       |
| Transfers in and/or out of Level 3(b)                          | -  | (10,850)                                |
|  | \$   | \$                                      |
| Ending balance at September 30, 2010                           | 42,742   | 42,742                                  |

(a) As a result of the increase in the fair value of our investments in auction rate securities, we recorded a net unrealized gain of \$265 and \$1,882 to Accumulated other comprehensive loss for the three and nine months ended September 30, 2010, respectively. The increase in unrealized gain was driven by stabilization and improvement within the municipal bond market throughout 2010.

(b) Auction rate securities in the amount of \$6,300 and \$4,550 were redeemed by the issuer at par in March and May 2010, respectively. Accordingly, we recorded an adjustment to the fair market valuation of these auction rate securities during the first and second quarter of 2010.

**Fair Value Measurements  
Using Significant  
Unobservable Inputs  
(Level 3)**

|  | <u>Three Months Ended<br/>September 30, 2009</u> | <u>Nine Months Ended<br/>September 30, 2009</u> |
|--|--|---|
| Beginning balance  | \$ 51,488  | \$ 54,972                                       |
| Realized gains (losses) in earnings (or changes in net assets) | -  | -   |
| Unrealized gains in other comprehensive income(a)              | 1,813  | 2,729   |
| Purchases, issuances and settlements                           | -  | -   |
| Transfers in and/or out of Level 3(b)                          | -  | (4,400)   |
|  | <u>\$ 53,301</u>                                 | <u>\$ 53,301</u>                                |
| Ending balance at September 30, 2009                           | <u>53,301</u>                                    | <u>53,301</u>                                   |

- (a) As a result of the increase in the fair value of our investments in auction rate securities, we recorded a net unrealized gain of \$1,813 and \$2,729 to Accumulated other comprehensive loss for the three and nine months ended September 30, 2009, respectively. The increase in unrealized gain was driven by the stabilization and improvement within the municipal bond market during 2009.
- (b) A \$4,400 auction rate security was redeemed by the issuer at par in February 2009. Accordingly, we recorded an adjustment to the fair market valuation of this auction rate security during the first quarter of 2009.

## 5. DEBT

We entered into a credit agreement on May 12, 2010, which was subsequently amended on May 25, 2010 (as amended, the "Credit Agreement"). The Credit Agreement provides for a \$65,000 committed revolving credit facility that expires on November 12, 2011. Borrowings under the Credit Agreement may be used for general corporate purposes.

The Credit Agreement is guaranteed by us and our subsidiaries, other than our HMO and insurance subsidiaries. In addition, the Credit Agreement is secured by first priority liens on our personal property and the personal property of our subsidiaries, other than the personal property and equity interests of our HMO and insurance subsidiaries.

Borrowings designated by us as Alternate Base Rate borrowings bear interest at a rate per annum equal to (i) the greatest of (a) the Prime Rate (as defined in the Credit Agreement) in effect on such day; (b) the Federal Funds Effective Rate (as defined in the Credit Agreement) in effect on such day plus 1/2 of 1%; and (c) the Adjusted LIBO Rate (as defined in the Credit Agreement) for a one month interest period on such day plus 1%; plus (ii) 1.5%. Borrowings designated by us as Eurodollar borrowings bear interest at a rate per annum equal to the Adjusted LIBO Rate for the interest period in effect for such borrowing plus 2.5%.

The Credit Agreement includes negative covenants that limit certain of our activities, including restrictions on our ability to incur additional indebtedness, and financial covenants that require a minimum ratio of cash flow to total debt, a maximum ratio of total liabilities to consolidated net worth and a minimum level of statutory net worth for our HMO and insurance subsidiaries.

The Credit Agreement also contains customary representations and warranties that must be accurate in order for us to borrow under the Credit Agreement. In addition, the Credit Agreement contains customary events of default. If an event of default occurs and is continuing, we may be required to immediately repay all amounts outstanding under the Credit Agreement, and the commitments under the Credit Agreement may be terminated.

As of September 30, 2010, the credit facility has not been drawn upon and we remain in compliance with all covenants.

## 6. INCOME TAXES

We file our income tax returns in the U.S. federal jurisdiction and various states. The U.S. Internal Revenue Service recently completed its "limited scope" examination of our federal income tax return for the 2008 tax year with no significant changes to our tax return. We are still undergoing state examinations for the 2004-2007 tax years in which disputes with state taxing authorities have yet to be resolved. We currently believe that none of these disputes, when finally concluded, will have a material adverse effect on our financial position, results of operations or cash flows.

Our effective income tax rate on pre-tax income for the three months ended September 30, 2010 was 41.3% compared to 37.6% on pre-tax income for the three months ended September 30, 2009. Our effective income tax rate on pre-tax loss for the nine months ended September 30, 2010 was 26.9%, which was lower than the statutory tax rate primarily due to limitations on the deductibility of certain administrative expenses associated with the resolution of investigation-related matters as well as certain executive compensation costs. Additionally, in 2010, certain investigation-related costs that were originally believed to be non-deductible for tax purposes during 2009, were ultimately identified as tax deductible and are reflected in our effective tax rate for the nine months ended September 30, 2010. Our effective tax rate on pre-tax income for the nine months ended September 30, 2009 was 61.1%, which was higher than the statutory tax rate due primarily to non-deductible costs incurred in conjunction with resolving certain investigation-related matters.

We have reclassified deferred taxes on uncertain tax positions from Other assets to non-current Deferred income tax assets on our Condensed Consolidated Balance Sheets as of September 30, 2010 and December 31, 2009.

## 7. COMMITMENTS AND CONTINGENCIES

### *Government Investigations*

As previously disclosed, in May 2009, we entered into a Deferred Prosecution Agreement (the "DPA") with the United States Attorney's Office for the Middle District of Florida (the "USAO") and the Florida Attorney General's Office, resolving previously disclosed investigations by those offices.

Under the one-count criminal information (the "Information") filed with the United States District Court for the Middle District of Florida (the "Federal Court") by the USAO pursuant to the DPA, we were charged with one count of conspiracy to commit health care fraud against the Florida Medicaid Program in connection with reporting of expenditures under certain community behavioral health contracts, and against the Florida Healthy Kids programs, under certain contracts, in violation of 18 U.S.C. Section 1349. The USAO recommended to the Court that the prosecution be deferred for the duration of the DPA. Within five days of the expiration of the DPA the USAO will seek dismissal with prejudice of the Information, provided we have complied with the DPA.

The term of the DPA is thirty-six months, but such term may be reduced by the USAO to twenty-four months upon consideration of certain factors set forth in the DPA, including our continued remedial actions and compliance with all federal and state health care laws and regulations.

In accordance with the DPA, the USAO has filed, with the Federal Court, a statement of facts relating to this matter. As a part of the DPA, we have retained an independent monitor (the "Monitor") for a period of 18 months from his retention in August 2009. The Monitor was selected by the USAO after consultation with us and is retained at our expense. In addition, we agreed to continue undertaking remedial measures to ensure full compliance with all federal and state health care laws. Among other things, the Monitor is reviewing our compliance with the DPA and all applicable federal and state health care laws, regulations and programs. The Monitor also is reviewing, evaluating and, as necessary, making written recommendations concerning certain of our policies and procedures. The DPA provides that the Monitor will undertake to avoid the disruption of our ordinary business operations or the imposition of unnecessary costs or expenses.

The DPA does not, nor should it be construed to, operate as a settlement or release of any civil or administrative claims for monetary, injunctive or other relief against us, whether under federal, state or local statutes, regulations or common law. Furthermore, the DPA does not operate, nor should it be construed, as a concession that we are entitled to any limitation of our potential federal, state or local civil or administrative liability. Pursuant to the terms of the DPA, we have paid the USAO a total of \$80,000.

In May 2009, we resolved the previously disclosed investigation by the SEC. Under the terms of the Consent and Final Judgment, without admitting or denying the allegations in the complaint filed by the SEC, we consented to the entry of a permanent injunction against any future violations of certain specified provisions of the federal securities laws. Pursuant to the terms of the Consent and Final Judgment, we have paid the SEC a total of \$10,000.

In October 2008, the Civil Division of the United States Department of Justice (the "Civil Division") informed us that as part of the pending civil inquiry, it is investigating four *qui tam* complaints filed by relators against us under the whistleblower provisions of the False Claims Act, 31 U.S.C. sections 3729-3733. The seal in those cases was partially lifted for the purpose of authorizing the Civil Division to disclose to us the existence of the *qui tam* complaints. In May 2010, as part of the ongoing resolution discussions with the Civil Division, we were provided with a copy of the *qui tam* complaints, in response to our request, which otherwise remained under seal as required by 31 U.S.C. section 3730(b)(3).

As previously disclosed, we also learned from a docket search that a former employee filed a *qui tam* action on October 25, 2007 in state court for Leon County, Florida against several defendants, including us and one of our subsidiaries (the "Leon County *qui tam* suit"). As part of our discussions to resolve pending *qui tam* and related civil investigations discussed above, we have been informed that the Leon County *qui tam* suit was filed by one of the federal *qui tam* relators and contains allegations similar to those alleged in one of the recently unsealed *qui tam* complaints.

On June 24, 2010, (i) the United States government filed its Notice of Election to Intervene in three of the *qui tam* matters, and (ii) we announced that we reached a preliminary agreement (the "Preliminary Settlement") with the Civil Division, the Civil Division of the USAO, and the Civil Division of the United States Attorney's Office for the District of Connecticut to settle their pending inquiries. On June 25, 2010, the Federal Court lifted the seal in the three *qui tam* complaints in which the government had intervened. Those complaints are now publicly available. In October 2010, the USAO filed a motion in one of the *qui tam* matters seeking a temporary stay of discovery.

The Preliminary Settlement is subject to completion and approval of an executed written settlement agreement and other government approvals. If any party objects to the Preliminary Settlement, the Federal Court will conduct a hearing to determine whether the proposed settlement is fair, adequate and reasonable under all the circumstances. Upon execution of the settlement agreement, we would, among other things, agree to pay the Civil Division a total of \$137,500 (the "Settlement Amount"), for which the first installment will be due after a written settlement agreement has been executed and three subsequent installments will be paid over a period of up to 36 months after the date of that executed written settlement agreement (the "Payment Period") plus interest at the rate of 3.125% per year. The Preliminary Settlement includes an acceleration clause that would require immediate payment of the remaining balance of the Settlement Amount in the event that we were acquired or otherwise experienced a change in control during the Payment Period. In addition, the Preliminary Settlement provides for a contingent payment of an additional \$35,000 in the event that we are acquired or otherwise experience a change in control within three years of the execution of the settlement agreement and provided that the change in control transaction exceeds certain minimum transaction value thresholds to be specified in the settlement agreement. We expect that the final settlement agreement will provide that the Settlement Amount will include approximately \$22,938 owed to the Florida Agency for Health Care Administration ("AHCA") as a result of overpayments received by us from AHCA during the three month period of August 2005 through October 2005. These overpayments were the result of a change implemented by AHCA in the payment methodology relating to medical benefits for newborns.

We have discounted the total liability of \$137,500 for the resolution of these matters and accrued this amount at its estimated fair value, which amounted to approximately \$136,345 at September 30, 2010. Approximately \$32,081 and \$104,264 has been included in the current and long-term portions, respectively, of Amounts accrued related to the investigation resolution in our Condensed Consolidated Balance Sheet as of September 30, 2010. There can be no assurance that the Preliminary Settlement will be finalized and approved and the actual outcome of these matters may differ materially from the terms of the Preliminary Settlement.

As previously disclosed, we remain engaged in resolution discussions as to matters under review with the United States Department of Health and Human Services' Office of Inspector General (the "OIG"). Those discussions are ongoing and no final resolution has been reached.

### ***Putative Class Action Complaints***

Putative class action complaints were filed in October 2007 and in November 2007. These putative class actions, entitled *Eastwood Enterprises, L.L.C. v. Farha, et al.* and *Hutton v. WellCare Health Plans, Inc. et al.*, respectively, were filed in Federal Court against us, Todd Farha, our former chairman and chief executive officer, and Paul Behrens, our former senior vice president and chief financial officer. Messrs. Farha and Behrens were also officers of various subsidiaries of ours. The *Eastwood Enterprises* complaint alleges that the defendants materially misstated our reported financial condition by, among other things, purportedly overstating revenue and understating expenses in amounts unspecified in the pleading in violation of the Securities Exchange Act of 1934, as amended (“Exchange Act”). The *Hutton* complaint alleges that various public statements supposedly issued by the defendants were materially misleading because they failed to disclose that we were purportedly operating our business in a potentially illegal and improper manner in violation of applicable federal guidelines and regulations. The complaint asserts claims under the Exchange Act. Both complaints seek, among other things, certification as a class action and damages. The two actions were consolidated, and various parties and law firms filed motions seeking to be designated as Lead Plaintiff and Lead Counsel. In an Order issued in March 2008, the Federal Court appointed a group of five public pension funds from New Mexico, Louisiana and Chicago (the “Public Pension Fund Group”) as Lead Plaintiffs. In October 2008, an amended consolidated complaint was filed in this class action asserting claims against us, Messrs. Farha and Behrens, and adding Thaddeus Bereday, our former senior vice president and general counsel, as a defendant. In January 2009, we and certain other defendants filed a joint motion to dismiss the amended consolidated complaint, arguing, among other things, that the complaint failed to allege a material misstatement by defendants with respect to our compliance with marketing and other health care regulations and failed to plead facts raising a strong inference of scienter with respect to all aspects of the purported fraud claim. The Federal Court denied the motion in September 2009 and we and the other defendants filed our answer to the amended consolidated complaint in November 2009.

In April 2010, the Lead Plaintiffs filed their motion for class certification. On June 18, 2010, the USAO filed motions seeking to intervene and for a temporary stay of discovery of this matter. In July 2010, the Federal Court granted the United States’ motions and ordered that discovery be stayed through December 2010.

On August 6, 2010, we reached agreement with the Lead Plaintiffs on the material terms of a settlement to resolve this matter. The terms of the settlement are being documented in a formal settlement agreement that will be subject to approval by the Federal Court following notice to all class members. The settlement provides that we will make cash payments to the class of \$52,500 within thirty business days following the Federal Court’s preliminary approval of the settlement and \$35,000 by July 31, 2011. The settlement also provides that we will issue to the class tradable unsecured bonds having an aggregate face value of \$112,500, with a fixed coupon of 6% and a maturity date of December 31, 2016. The bonds shall also provide that, if we incur debt obligations in excess of \$425,000 that are senior to the bonds, the bonds shall accelerate as to payment and be redeemed. The settlement has two further contingencies. First, it provides that if, within three years following the date of the settlement agreement, the Company is acquired or otherwise experiences a change in control at a share price of \$30.00 or more, we will pay to the class an additional \$25,000. Second, the settlement provides that we will pay to the class 25% of any sums we recover from Messrs. Farha, Behrens and/or Bereday as a result of claims arising from the same facts and circumstances that gave rise to this matter. We may terminate the settlement if a certain number or percentage of the class opt out of the settlement class. The settlement agreement will also provide that the settlement does not constitute an admission of liability by any party and such other terms as are customarily contained in settlement agreements of similar matters.

As a result of this settlement having been reached, our current estimate for the resolution of this matter is \$200,000. We have discounted the \$200,000 liability for the resolution of this matter and accrued this amount at its estimated fair value, which amounted to approximately \$194,905 at September 30, 2010. Approximately \$85,520 and \$109,385 have been included in the current and long-term portions, respectively, of Amounts accrued related to investigation resolution in our Condensed Consolidated Balance Sheet as of September 30, 2010. There can be no assurance that the settlement will be finalized and approved and the actual outcome of this matter may differ materially from the terms of the settlement.

## Derivative Lawsuits

As previously disclosed, in connection with our government investigations, five putative stockholder derivative actions were filed between October and November 2007. Four of these actions were asserted against directors Kevin Hickey and Christian Michalik, our current directors who were directors prior to 2007, and against former directors Regina Herzlinger, Alif Hourani, Ruben King-Shaw and Neal Moskowski, and former director and officer Todd Farha. These actions also name us as a nominal defendant. Two of these actions were filed in the Federal Court and two actions were filed in the Circuit Court for Hillsborough County, Florida (the "State Court"). The fifth action, filed in the Federal Court, asserts claims against directors Robert Graham, Kevin Hickey and Christian Michalik, our current directors who were directors at the time the action was filed, and against former directors Regina Herzlinger, Alif Hourani, Ruben King-Shaw and Neal Moskowski, former director and officer Todd Farha, and former officers Paul Behrens and Thaddeus Bereday. A sixth derivative action was filed in January 2008 in the Federal Court and asserted claims against all of these defendants except Robert Graham. All six of these actions contend, among other things, that the defendants allegedly allowed or caused us to misrepresent our reported financial results, in amounts unspecified in the pleadings, and seek damages and equitable relief for, among other things, the defendants' supposed breach of fiduciary duty, waste and unjust enrichment. In April 2009, upon the recommendation of the Nominating and Corporate Governance Committee of the Board, the Board formed a Special Litigation Committee, comprised of a newly-appointed independent director, to investigate the facts and circumstances underlying the claims asserted in the derivative cases and to take such action with respect to these claims as the Special Litigation Committee determines to be in our best interests. In November 2009, the Special Litigation Committee filed a report with the Federal Court determining, among other things, that we should pursue an action against three of our former officers. In December 2009, the Special Litigation Committee filed a motion to dismiss the claims against the director defendants and to realign us as a plaintiff for purposes of pursuing claims against former officers Messrs. Farha, Behrens and Bereday.

In March 2010, a Stipulation of Partial Settlement ("Stipulation I") was filed in the Federal Court. Under the terms of Stipulation I, the plaintiffs in the federal action have agreed that the Special Litigation Committee's motion to dismiss the director defendants and to realign us as a plaintiff should be granted in its entirety. The plaintiffs in the consolidated federal putative shareholder derivative actions also agreed to dismiss their claims against Messrs. Farha, Behrens and Bereday. In turn, we have paid to plaintiffs' counsel in the federal action attorneys' fees in the amount of \$1,688. This amount has been included in the Other accrued expenses and liabilities line item in our Condensed Consolidated Balance Sheet as of September 30, 2010. In April 2010, the Federal Court entered an order preliminarily approving Stipulation I and directing us to provide notice to our shareholders. The Federal Court also approved Stipulation I and granted our motion to dismiss the director defendants and realigned us as the plaintiff in this action in July 2010. The case is now styled *WellCare v. Farha, et al.* In July 2010, the Federal Court stayed discovery through December 2010. In August 2010, Messrs. Farha, Behrens and Bereday filed a notice of appeal in the United States Court of Appeals for the Eleventh Circuit (the "Court of Appeals"), which was dismissed for lack of jurisdiction in October 2010. The defendants have moved for reconsideration of the Court of Appeals' order of dismissal.

In April 2010, a second Stipulation of Partial Settlement ("Stipulation II") was filed in the State Court. Under the terms of Stipulation II, the plaintiffs in the state action agreed that the Special Litigation Committee's motion to dismiss the director defendants and to realign us as a plaintiff should be granted in its entirety. In turn, we have paid to plaintiffs' counsel in the state action attorneys' fees in the amount of \$563. This amount was included in the Other accrued expenses and liabilities line item in our Condensed Consolidated Balance Sheet as of September 30, 2010. The State Court approved Stipulation II and granted our motion to dismiss the director defendants and realigned us as the plaintiff in this action in June 2010. In July 2010, Mr. Farha filed a notice of appeal in this matter, which remains pending.

In October 2010, we filed a motion for leave to file an amended complaint against Mr. Farha in the State Court action and a new lawsuit in Federal Court against Messrs. Behrens and Bereday, stating claims for breach of contract and breach of their fiduciary duties.

### ***Other Lawsuits and Claims***

In October 2009, an action was filed against us in the Court of Chancery of the State of Delaware ("Court of Chancery") entitled *Behrens, et al. v. WellCare Health Plans, Inc.* in which the plaintiffs, Messrs. Behrens, Bereday, and Farha, seek an order requiring us to pay their respective expenses, including attorney fees, in connection with litigation and investigations in which the plaintiffs are involved by reason of their service as our directors and officers. Plaintiffs further challenge our right, prior to advancing such expenses, to first submit their expense invoices to our directors' and officers' insurance carrier for their preliminary review and evaluation of the adequacy of the description of services in the invoices and of the reasonableness of those expenses. We have reached an agreement to resolve this matter and will continue to pay their respective expenses, including attorney fees, under certain terms, in connection with the investigations and litigation. Pursuant to the terms of this agreement, in September 2010, the Court of Chancery entered a partial consent judgment and order which governs the terms under which we must continue to pay Messrs. Behrens, Bereday and Farha's respective expenses.

Separate and apart from the legal matters described above, we are also involved in other legal actions that are in the normal course of our business, including, without limitation, provider disputes regarding payment of claims and disputes relating to the performance of contractual obligations with state agencies, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We currently believe that none of these actions, when finally concluded and determined, will have a material adverse effect on our financial position, results of operations or cash flows.

### ***Directors and Officers Insurance Recovery***

In August 2010, we entered into an agreement and release with the carriers of our directors and officers ("D&O") liability insurance relating to coverage we sought for claims relating to the previously disclosed government investigations and related litigation. We agreed to accept immediate settlement of \$32,500, \$7,400 of which was previously received under the policy and recorded in prior periods in satisfaction of the \$45,000 face amount of the relevant D&O insurance policies and the carriers agreed to waive any rights they may have to challenge our coverage under the policies. The agreement and release did not include a \$10,000 face amount policy we maintain for non-indemnifiable securities claims by directors and officers during the same time period and such policy is not affected by the agreement and release. Accordingly, we recorded \$25,100 and \$25,800 during the three and nine months ended September 30, 2010, respectively, of expected insurance proceeds as a reduction to Selling, general and administrative expenses. Of this amount, \$19,650 was received as of September 30, 2010 with the remaining \$6,150 included in the Prepaid expenses and other current assets line item in our Condensed Consolidated Balance Sheet as of September 30, 2010. The remaining \$6,150 was collected in October 2010. No additional recoveries with respect to such matters are expected under our insurance policies and all expenses incurred by us in the future for these matters will not be further reimbursed by our insurance policies.

## **Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations.**

### **Forward Looking Statements**

This Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2010 ("2010 Form 10-Q") may include "forward-looking statements" within the meaning of Section 21E of the Securities Act of 1934, as amended, including, in particular, estimates, projections, guidance or outlook. Generally the words "believe," "expect," "anticipate," "may," "intend," "estimate," "anticipate," "plan," "project," "should" and similar expressions identify forward-looking statements, which generally are not historical in nature. These statements may contain information about financial prospects, economic conditions and trends that involve risks and uncertainties. Please refer to Risk Factors in Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2009 ("2009 Form 10-K") and in Part II, Item 1A of this 2010 Form 10-Q, for a discussion of certain risk factors which could materially affect our business, financial condition, cash flows, or results of operations. If any of those risks, or other risks not presently known to us or that we currently believe to not be significant, do materialize or develop into actual events, our business, financial condition, results of operations or prospects could be materially adversely affected. Given these risks and uncertainties, we can give no assurances that any results or events projected or contemplated by our forward-looking statements will in fact occur and we caution you not to place undue reliance on these statements. We caution you that we do not undertake any obligation to update forward-looking statements made by us.

### **Overview**

#### ***Executive Summary***

We provide managed care services exclusively to government-sponsored health care programs, serving approximately 2.2 million members as of September 30, 2010. We believe that our broad range of experience and exclusive government focus allows us to efficiently and effectively serve our members and partner with our providers and government clients, while managing our ongoing operations. Our strategic priorities for 2010 include improving health care quality and access for our members, ensuring a competitive cost position and committing to prudent and profitable growth. We continue to work closely with providers and government clients to further enhance health care delivery and to improve the quality of, and enhance access to, government health care services for our members. Our cost management initiatives are concentrated on aligning our expense structure with our current revenue base through process improvement and other initiatives; focusing on ensuring a competitive cost position in terms of both administrative and medical expenses. We are also focused on programs that help governments provide quality care within their fiscal constraints and present us with long-term opportunities for prudent and profitable growth.

#### ***General Economic and Political Environment***

The current economic and political environment is affecting our business in a number of ways, as more fully described throughout this 2010 Form 10-Q.

#### ***Premium Rates and Payments***

The states in which we operate continue to experience fiscal challenges which have led to budget cuts and reductions in Medicaid premiums in certain states or rate increases that are below medical cost trends. In particular, we continue to experience pressure on rates in Florida and Georgia, two states from which we derive a substantial portion of our revenue. We experienced rate increases in most of our Medicaid markets during the third quarter, including net increases of approximately 2.5-3.0% in Florida effective September 1, 2010 and 1.5-2.0% in Georgia effective July 1, 2010, that were below medical cost trends. Hawaii program rate increases, which we believe have improved the stability of the program, also were effective July 1, 2010. New York program rate increases were also implemented during the third quarter that were effective April 1, 2010. Although premiums are generally contractually payable to us before or during the month in which we are obligated to provide services to our members, we have experienced delays in premium payments from certain states. In particular, the State of Georgia recently passed legislation mandating that payment for Medicaid premiums in that state be made at the end of the month in which services are provided. Although this legislation becomes effective in June 2011, the State of Georgia has already implemented this change. Prior to this change, such payments were made at the beginning of each month. Given the budget shortfalls in many states with which we contract, additional payment delays may occur in the future. Separately, the Centers for Medicare & Medicaid Services ("CMS") implemented a reduction in Medicare Advantage ("MA") reimbursements of 1.6% for 2011. We expect the reduction in 2011 MA rates will be outpaced by medical cost trends, placing continued importance on ongoing improvements in administrative costs and effective medical cost initiatives.

In 2009, as part of the American Recovery and Reinvestment Act, Congress increased the Federal Medical Assistance Percentages (“FMAP”), temporarily increasing federal funding for state Medicaid programs. The policy rationale was to help relieve states’ fiscal problems in the face of declining revenues and rising Medicaid enrollments due to the economic downturn. The enhanced FMAP was set to expire at the end of 2010. The Senate and House of Representatives have separately passed legislation extending additional enhanced FMAP funding through June 2011.

### *Health Care Reform*

In March 2010, President Obama signed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the “2010 Acts”). We believe these laws will bring about significant changes to the American health care system. While these measures are intended to expand the number of United States citizens covered by health insurance and make other coverage, delivery, and payment changes to the current health care system, the costs of implementing the 2010 Acts will be financed, in part, by future reductions in the payments made to Medicare providers.

Provisions of the 2010 Acts will become effective over the next several years. Several departments within the federal government will issue regulations and guidance on implementing the 2010 Acts. Because final rules and guidance on key aspects of the legislation have not yet been promulgated by the government regulators, the impact of the 2010 Acts is still unknown. We believe that revisions to the existing system may put pressure on operating results, decrease member benefits, and/or increase member premiums, particularly with respect to MA plans.

The 2010 Acts include a number of changes to the way MA plans will operate in the future such as: deriving premium payments based on quality scores, establishing minimum medical loss ratios and new taxes and assessments. As part of the health care reform legislation, MA payment benchmarks for 2011 were frozen at 2010 levels. Beginning in 2012, MA plan premiums will be tied to quality measures and based on a CMS “5-star rating system.” This rating system will allow an MA plan to receive an increase in certain premium rates. It is unknown whether these ratings will be geographically or demographically adjusted. The final methodology used in the determination of our quality score, which continues to be developed by CMS, could impact our ability to provide additional benefits and entice new members. Beginning in 2014, MA plans with medical loss ratios below the targets prescribed will be required to return premiums to CMS each year. Guidance on calculating the minimum medical loss ratio has not yet been determined. These rules will include defining which expenses should be classified as medical expense for the calculation, such as utilization management; which taxes, fees and assessments will be excluded from premium; the period over which the ratio will be calculated; and whether the calculation will be on a whole company or some type of disaggregated basis. Given the significance of this portion of the new legislation and the lack of definitive guidance from the respective government agencies, we are not able to project fully the impact of the minimum medical loss ratio on our operating results and cash flows.

The health reforms in the 2010 Acts present several challenges as well as opportunities for our Medicaid business. We anticipate that the reforms could significantly increase the number of citizens who are eligible to enroll in our Medicaid products. However, state budgets continue to be strained due to economic conditions and uncertain levels of federal financing for current populations. As a result, the effects of any potential future expansions are uncertain, making it difficult to determine whether the 2010 Acts will have a positive or negative impact on our Medicaid business.

The 2010 Acts also include an annual assessment on the insurance industry beginning in 2014. The legislation anticipates that the \$8 billion insurance industry assessment is likely to increase in subsequent years. Due to the lack of regulations and guidance, we are unable to project the impact this additional tax will have on our operating results and cash flows.

## ***Business and Financial Outlook***

### *Business Trends*

Our revenues and medical benefits expenses for fiscal year 2010 will be lower than in prior periods due to our exit on December 31, 2009 from our MA private fee-for-service (“PFFS”) product and our exit from Medicaid programs in certain Florida counties during 2009. Premium revenue from our PFFS product represented approximately 40.9% of our MA reportable operating segment revenue and 16.5% of our consolidated premium revenue for the 2009 fiscal year. We anticipate that the withdrawal from the PFFS product may provide approximately \$40.0 million to \$60.0 million of excess capital in the insurance companies that underwrote this line of business, which we may be able to distribute to our unregulated subsidiaries through dividends. However, we currently believe we will not have the benefit of these dividends prior to 2011, if at all. Any dividend of surplus capital of our applicable insurance subsidiaries, including the timing and amount of any dividend, would be subject to a variety of factors, which could materially change the aforementioned timing and amount. Those factors include the ultimate financial performance of the PFFS product as well as the financial performance of other lines of business that operate in those insurance subsidiaries, approval from regulatory agencies and potential changes in regulatory capital requirements. For example, our current estimate of \$40.0 million to \$60.0 million declined from previous estimates, because the financial performance of these insurance subsidiaries worsened during 2009.

During 2009, CMS imposed a marketing sanction against us that prohibited us from the marketing of, and enrolling members into, all lines of our Medicare business from March until the sanction was released in November. As a result of the sanction, we were not eligible to receive auto-assignment of low-income subsidy (“LIS”) dual-eligible beneficiaries into our prescription drug plans (“PDP”) for January 2010 enrollment. We received auto-assignment of such members in subsequent months, although such assignments were at levels well below the level we typically experience in the month of January.

Based on the outcome of our 2011 PDP bids, which resulted in our plans being below the benchmarks in 20 of the 34 CMS regions, up from 19 regions in 2010, we will be eligible for auto-assignment of LIS beneficiaries in those 20 regions for January 2011 enrollment.

A number of states in which we operate held gubernatorial elections on November 2, 2010. Administration changes occurred in nearly all of our current Medicaid markets. Once sworn in, new governors may seek changes to the Medicaid program which could positively or adversely impact our operations, enrollment, premiums or earnings.

### *Financial Impact of Government Investigations and Litigation*

As previously disclosed, pursuant to our consent to the entry of a final judgment against us in the United States District Court for the Middle District of Florida (the “Federal Court”) to resolve the previously disclosed informal investigation conducted by the United States Securities and Exchange Commission (the “SEC”), we have paid a civil penalty in the aggregate amount of \$10.0 million and disgorgement in the amount of one dollar plus post-judgment interest. As previously disclosed, we remain engaged in resolution discussions as to matters under review with the United States Department of Health and Human Services’ Office of Inspector General (the “OIG”).

In June 2010 we announced that we had reached a preliminary agreement (the “Preliminary Settlement”) with the United States Department of Justice’s Civil Division (the “Civil Division”) to settle its inquiries. The Preliminary Settlement is subject to, among other things, completion of an executed written settlement agreement and other government approvals. Pursuant to the terms of the Preliminary Settlement we would agree to, among other things, pay the Civil Division a total of \$137.5 million, for which the first installment will be due after an agreement has been executed and three subsequent installments will be paid over a period of up to 36 months after the date of that executed agreement plus interest at the rate of 3.125% per year. We have discounted the total liability of \$137.5 million for the resolution of these matters and accrued this amount at its estimated fair value, which amounted to approximately \$136.3 million at September 30, 2010. There can be no assurance that the Preliminary Settlement will be finalized and approved and the actual outcome of these matters may differ materially from the terms of the Preliminary Settlement.

In April 2010, the Lead Plaintiffs in the putative class action complaints filed against us in 2007 entitled *Eastwood Enterprises, L.L.C. v. Farha, et al.* and *Hutton v. WellCare Health Plans, Inc. et al.*, filed their motion for class certification. On June 18, 2010, the USAO filed motions seeking to intervene and for a temporary stay of discovery of this matter. In July 2010, the Federal Court granted the United States' motions and ordered that discovery be stayed until December 2010. On August 6, 2010, we reached agreement with the Lead Plaintiffs on the material terms of a settlement to resolve this matter. The terms of the settlement will be documented in a formal settlement agreement which is subject to approval by the Federal Court following notice to all class members. The settlement provides that we will make cash payments to the class of \$52.5 million within thirty business days following the Federal Court's preliminary approval of the settlement and \$35.0 million by July 31, 2011. The settlement also provides that we will issue to the class tradable unsecured bonds having an aggregate face value of \$112.5 million, with a fixed coupon of 6% and a maturity date of December 31, 2016. The bonds shall also provide that, if we incur debt obligations in excess of \$425.0 million that are senior to the bonds, the bonds shall accelerate as to payment and be redeemed. The settlement has two further contingencies. First, it provides that if, within three years following the date of the settlement agreement, the Company is acquired or otherwise experiences a change in control at a share price of \$30.00 or more, we will pay to the class an additional \$25.0 million. Second, the settlement provides that we will pay to the class 25% of any sums we recover from Messrs. Farha, Behrens and/or Bereday as a result of claims arising from the same facts and circumstances that gave rise to this matter. We may terminate the settlement if a certain number or percentage of the class opt out of the settlement class. The settlement agreement will also provide that the settlement does not constitute an admission of liability by any party and such other terms as are customarily contained in settlement agreements of similar matters.

As a result of this settlement having been reached, our current estimate for the resolution of this matter is \$200.0 million. We have discounted the \$200.0 million liability for the resolution of this matter and accrued this amount at its estimated fair value, which amounted to approximately \$194.9 million at September 30, 2010. There can be no assurances that the ultimate resolution of this matter will not have a material adverse effect on our financial position, results of operations or cash flow.

#### *Investigation-Related Costs*

We have expended significant financial resources in connection with the investigations and related matters. Since the inception of these investigations through September 30, 2010, we have incurred a total of approximately \$193.0 million for administrative expenses associated with, or consequential to, these governmental and Company investigations specifically for legal fees, accounting fees, consulting fees, employee recruitment and retention costs and other similar expenses, prior to any insurance recoveries. In August 2010, we entered into an agreement and release with the carriers of our directors and officers ("D&O") liability insurance relating to coverage we sought for claims relating to the previously disclosed government investigations and related litigation. We agreed to accept immediate settlement of \$32.5 million, of which \$7.4 million previously received under the policy and recorded in prior periods in satisfaction of the \$45.0 million face amount of the relevant D&O insurance policies and the carriers agreed to waive any rights they may have to challenge our coverage under the policies. The agreement and release did not include a \$10.0 million face amount policy we maintain for non-indemnifiable securities claims by directors and officers during the same time period and such policy is not affected by the agreement and release. We expect to continue incurring additional costs in connection with the resolution of these matters including shareholder actions and compliance with the previously disclosed Deferred Prosecution Agreement we entered in May 2009 with the United States Attorney's Office for the Middle District of Florida and the Florida Attorney General's Office, resolving previously disclosed investigations by those offices and related matters during its term. We can provide no assurance that such costs will not be significant or increase in the future. We currently maintain directors and officers liability insurance in the amount of \$175.0 million for other matters not addressed above.

#### **Basis of Presentation**

##### *Segments*

Reportable operating segments are defined as components of an enterprise for which discrete financial information is available and evaluated on a regular basis by the chief operating decision-maker to determine how resources should be allocated to an individual segment and to assess performance of those segments. Previously, we reported two operating segments, Medicaid and Medicare, which coincide with our two main business lines. During the first quarter of 2010, we reassessed our segment reporting practices and made revisions to reflect our current method of managing performance and determining resource allocation, which includes reviewing the results of our PDP operations separately from other Medicare products. Accordingly, we now have three reportable segments within our two main business lines: Medicaid, MA and PDP. The PFFS product that we exited December 31, 2009 is reported within the MA segment. The prior periods have been revised to reflect this segment presentation.

We use three measures to assess the performance of our reportable business segments: premium revenue, medical benefits ratio ("MBR") and gross margin. Our MBR represents the ratio of our medical benefits expense to premiums earned. Our gross margin is defined as our premium revenue less our medical benefits expense.

Our profitability depends in large part on our ability to, among other things, effectively price our health and prescription drug plans; manage medical benefits expense, including reserve estimates and pharmacy costs; contract with health care providers; and attract and retain members. In addition, factors such as regulation, competition and general economic conditions affect our operations and profitability. The effect of escalating health care costs, as well as any changes in our ability to negotiate competitive rates with our providers may impose further risks to our profitability and may have a material impact on our business, financial condition and results of operations.

#### *Medicaid*

Medicaid was established to provide medical assistance to low-income and disabled persons. It is state operated and implemented, although it is funded and regulated by both the state and federal governments. Our Medicaid segment includes plans for beneficiaries of Temporary Assistance for Needy Families (“TANF”) programs, Supplemental Security Income (“SSI”) programs, Aged Blind and Disabled (“ABD”) programs and state-based programs that are not part of the Medicaid program, such as Children’s Health Insurance Programs (“CHIP”) and Family Health Plus (“FHP”) programs for qualifying families who are not eligible for Medicaid because they exceed the applicable income thresholds. TANF generally provides assistance to low-income families with children; ABD and SSI generally provide assistance to low-income aged, blind or disabled individuals.

The Medicaid programs and services we offer to our members vary by state and county and are designed to serve our various constituencies effectively in the communities we serve. Although our Medicaid contracts determine to a large extent the type and scope of health care services that we arrange for our members, in certain markets we customize our benefits in ways that we believe make our products more attractive. Our Medicaid plans provide our members with access to a broad spectrum of medical benefits from many facets of primary care and preventive programs to full hospitalization and tertiary care.

In general, members are required to use our network, except in cases of emergencies, transition of care or when network providers are unavailable to meet their medical needs, and generally must receive a referral from their primary care physician (“PCP”) in order to receive health care from specialists, such as surgeons or neurologists. Members do not pay any premiums, deductibles or co-payments for most of our Medicaid plans.

#### *Medicare Advantage*

Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons a variety of hospital, medical and prescription drug benefits. Our MA segment consists of MA plans, which following the exit of our PFFS product on December 31, 2009, is comprised of coordinated care plans (“CCPs”). MA is Medicare’s managed care alternative to original Medicare fee-for-service (“Original Medicare”), which provides individuals standard Medicare benefits directly through CMS. CCPs are administered through health maintenance organizations (“HMOs”) and generally require members to seek health care services and select a PCP from a network of health care providers. In addition, we offer Medicare Part D coverage, which provides prescription drug benefits, as a component of our MA plans.

We cover a wide spectrum of medical services through our MA plans, including in some cases, additional benefits not covered by Original Medicare, such as vision, dental and hearing services. Through these enhanced benefits, the out-of-pocket expenses incurred by our members are reduced, which allows our members to better manage their health care costs.

Most of our MA plans require members to pay a co-payment, which varies depending on the services and level of benefits provided. Typically, members of our MA CCPs are required to use our network of providers except in cases such as emergencies, transition of care or when specialty providers are unavailable to meet a member’s medical needs. MA CCP members may see out-of-network specialists if they receive referrals from their PCPs and may pay incremental cost-sharing. In most of our markets, we also offer special needs plans to individuals who are dually eligible for Medicare and Medicaid. These plans, commonly called D-SNPs, are designed to provide specialized care and support for beneficiaries who are eligible for both Medicare and Medicaid. We believe that our D-SNPs are attractive to these beneficiaries due to the enhanced benefit offerings and clinical support programs.

#### *Prescription Drug Plans*

We offer stand-alone Medicare Part D coverage to Medicare-eligible beneficiaries through our PDP segment. The Medicare Part D prescription drug benefit is supported by risk sharing with the federal government through risk corridors designed to limit the losses and gains of the drug plans and by reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for risk factor payments. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries. The Medicare Part D program offers national in-network prescription drug coverage that is subject to limitations in certain circumstances.

Depending on medical coverage type, a beneficiary has various options for accessing drug coverage. Beneficiaries enrolled in Original Medicare can either join a stand-alone PDP or forego Part D drug coverage. Beneficiaries enrolled in MA CCPs can join a plan with Part D coverage, select a separate Part D plan, or forego Part D coverage.

## Gross Margin and Medical Benefits Ratio

Our primary tools for measuring profitability are gross margin and MBR. Changes in gross margin and MBR from period to period result from, among other things, changes in Medicaid and Medicare funding, changes in the mix of Medicaid and Medicare membership, our ability to manage medical costs and changes in accounting estimates related to claims incurred but not reported (“IBNR”). Estimation of medical benefits payable and medical benefits expense is our most significant critical accounting estimate. See “Critical Accounting Estimates” below. We use gross margin and MBRs both to monitor our management of medical benefits and medical benefits expense and to make various business decisions, including what health care plans to offer, what geographic areas to enter or exit and which health care providers to select. Although gross margin and MBRs play an important role in our business strategy, we may be willing to enter new geographical markets and/or enter into provider arrangements that might produce a less favorable gross margin and MBR if those arrangements, such as capitation or risk sharing, would likely lower our exposure to variability in medical costs or for other reasons.

## Critical Accounting Estimates

In the ordinary course of business, we make a number of estimates and assumptions relating to the reporting of our results of operations and financial condition in conformity with accounting principles generally accepted in the United States (“GAAP”). We base our estimates on historical experience and on various other assumptions that we believe to be reasonable under the circumstances. Actual results could differ significantly from those estimates under different assumptions and conditions. We believe that our accounting policies relating to revenue recognition, medical benefits payable and medical benefits expense, and goodwill and intangible assets, are those that are most important to the portrayal of our financial condition and results and require management’s most difficult, subjective and complex judgments, often as a result of the need to make estimates about the effect of matters that are inherently uncertain. We have not changed these policies from those previously disclosed in our 2009 Form 10-K. Our critical accounting estimates relating to medical benefits payable and medical benefits expense, and the quantification of the sensitivity of financial results to reasonably possible changes in the underlying assumptions used in such estimation as of September 30, 2010, is discussed below. Additionally, we continually assess our estimates related to goodwill and intangible assets, which is discussed in further detail below. There were no significant changes to the other critical accounting estimates disclosed in our 2009 Form 10-K.

### *Estimating Medical Benefits Payable and Medical Benefits Expense*

The cost of medical benefits is recognized in the period in which services are provided and includes an estimate of the cost of IBNR medical benefits. Medical benefits payable has two main components: direct medical expenses and medically-related administrative costs. Direct medical expenses include amounts paid or payable to hospitals, physicians and providers of ancillary services, such as laboratories and pharmacies. Medically-related administrative costs include items such as case and disease management, utilization review services, quality assurance and on-call nurses, which are recorded in Selling, general, and administrative expense. Medical benefits payable on our Condensed Consolidated Balance Sheets represents amounts for claims fully adjudicated awaiting payment disbursement of \$53.9 million and \$53.0 million, and estimates for IBNR of \$649.8 million and \$749.5 million, as of September 30, 2010 and December 31, 2009, respectively.

The medical benefits payable estimate has been and continues to be our most significant estimate included in our financial statements. We historically have used and continue to use a consistent methodology for estimating our medical benefits expense and medical benefits payable. Our policy is to record management’s best estimate of medical benefits payable based on the experience and information available to us at the time. This estimate is determined utilizing standard actuarial methodologies based upon historical experience and key assumptions consisting of trend factors and completion factors using an assumption of moderately adverse conditions, which vary by business segment. These standard actuarial methodologies include using, among other factors, contractual requirements, historic utilization trends, the interval between the date services are rendered and the date claims are paid, denied claims activity, disputed claims activity, benefits changes, expected health care cost inflation, seasonality patterns, maturity of lines of business and changes in membership.

The factors and assumptions described above that are used to develop our estimate of medical benefits expense and medical benefits payable inherently are subject to greater variability when there is more limited experience or information available to us. The ultimate claims payment amounts, patterns and trends for new products and geographic areas cannot be precisely predicted at their onset, since we, the providers and the members do not have experience in these products or geographic areas. Standard accepted actuarial methodologies, discussed above, would allow for this inherent variability, which could result in larger differences between the originally estimated medical benefits payable and the actual claims amounts paid. Conversely, during periods where our products and geographies are more stable and mature, we have more reliable claims payment patterns and trend experience. With more reliable data, we should be able to more closely estimate the ultimate claims payment amounts; therefore, we may experience smaller differences between our original estimate of medical benefits payable and the actual claim amounts paid.

In developing our estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For the more recent months, which constitute the majority of the amount of the medical benefits payable, we estimate claims incurred by applying observed trend factors to the fixed fee per-member per-month (“PMPM”) costs for prior months, which costs have been estimated using completion factors, in order to estimate the PMPM costs for the most recent months. We validate our estimates of the most recent PMPM costs by comparing the most recent months’ utilization levels to the utilization levels in prior months and actuarial techniques that incorporate a historical analysis of claim payments, including trends in cost of care provided and timeliness of submission and processing of claims.

Many aspects of the managed care business are not predictable. These aspects include the incidences of illness or disease state (such as congestive heart failure cases, cases of upper respiratory illness, the length and severity of the flu season, diabetes, the number of full-term versus premature births and the number of neonatal intensive care babies). Therefore, we must continually monitor our historical experience in determining our trend assumptions to reflect the ever-changing mix, needs and size of our membership. Among the factors considered by management are changes in the level of benefits provided to members, seasonal variations in utilization, identified industry trends and changes in provider reimbursement arrangements, including changes in the percentage of reimbursements made on a capitation as opposed to a fee-for-service basis. These considerations are reflected in the trends in our medical benefits expense. Other external factors such as government-mandated benefits or other regulatory changes, catastrophes and epidemics may impact medical cost trends. Other internal factors such as system conversions and claims processing interruptions may impact our ability to accurately predict estimates of historical completion factors or medical cost trends. Medical cost trends potentially are more volatile than other segments of the economy. Management uses considerable judgment in determining medical benefits expense trends and other actuarial model inputs. We believe that the amount of medical benefits payable as of September 30, 2010 is adequate to cover our ultimate liability for unpaid claims as of that date; however, actual payments may differ from established estimates. If the completion factors we used in estimating our IBNR for the most recent nine months at September 30, 2010 were decreased by 1%, our net income would decrease by approximately \$42.2 million. If the completion factors were increased by 1%, our net income would increase by approximately \$41.3 million.

Also included in medical benefits payable are estimates for provider settlements due to clarification of contract terms, out-of-network reimbursement, claims payment differences as well as amounts due to contracted providers under risk-sharing arrangements. We record reserves for estimated referral claims related to health care providers under contract with us who are financially troubled or insolvent and who may not be able to honor their obligations for the costs of medical services provided by other providers. In these instances, we may be required to honor these obligations for legal or business reasons. Based on our current assessment of providers under contract with us, such losses have not been and are not expected to be significant.

Changes in medical benefits payable estimates are primarily the result of obtaining more complete claims information and medical expense trend data over time. Volatility in members’ needs for medical services, provider claims submissions and our payment processes result in identifiable patterns emerging several months after the causes of deviations from assumed trends occur. Since our estimates are based upon PMPM claims experience, changes cannot typically be explained by any single factor, but are the result of a number of interrelated variables, all influencing the resulting medical cost trend. Differences in our financial statements between actual experience and estimates used to establish the liability, which we refer to as prior period developments, are recorded in the period when such differences become known, and have the effect of increasing or decreasing the reported medical benefits expense and resulting MBR in such periods.

In establishing our estimate of reserves for IBNR at each reporting period, we use standard actuarial methodologies based upon historical experience and key assumptions consisting of trend factors and completion factors, which vary by business segment, to determine an estimate of the base reserve. Actuarial standards of practice require that a margin for uncertainty be considered in determining the estimate for unpaid claim liabilities. If a margin is included, the claim liabilities should be adequate under moderately adverse conditions. Therefore, we make an additional estimate in the process of establishing the IBNR, which also uses standard actuarial techniques, to account for adverse conditions that may cause actual claims to be higher than estimated compared to the base reserve, for which the model is not intended to account. We refer to this additional liability as the provision for moderately adverse conditions. The provision for moderately adverse conditions is a component of our overall determination of the adequacy of our IBNR reserve. The provision for moderately adverse conditions is intended to capture the potential adverse development from factors such as our entry into new geographical markets, our provision of services to new populations such as the aged, blind and disabled, the variations in utilization of benefits and increasing medical cost, changes in provider reimbursement arrangements, variations in claims processing speed and patterns, claims payment, the severity of claims, and outbreaks of disease such as the flu. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNR after considering the base actuarial model reserves and the provision for moderately adverse conditions. We consistently apply our IBNR estimation methodology from period to period. We review our overall estimates of IBNR on a monthly basis. As additional information becomes known to us, we adjust our assumptions accordingly to change our estimate of IBNR. Therefore, if moderately adverse conditions do not occur, evidenced by more complete claims information in the following period, then our prior period estimates will be revised downward, resulting in favorable development. However, any favorable prior period reserve development would affect (increase) current period net income only to the extent that the current period provision for moderately adverse conditions is less than the benefit recognized from the prior period favorable development. If moderately adverse conditions occur and are more than we estimated, then our prior period estimates will be revised upward, resulting in unfavorable development, which would decrease current period net income.

For the three months ended September 30, 2010, medical benefits expense was impacted by approximately \$4.1 million of net unfavorable development related to prior periods, which includes approximately \$6.9 million of favorable development related to prior fiscal years that was more than offset by \$11.0 million of unfavorable development that related to earlier periods in 2010. For the nine months ended September 30, 2010, medical benefits expense was impacted by approximately \$39.1 million of net favorable development related to prior years. For the three months ended September 30, 2009, medical benefits expense was impacted by approximately \$5.3 million of net unfavorable development related to prior periods, which included approximately \$4.9 million of favorable development related to prior fiscal years that was more than offset by \$10.2 million of unfavorable development that related to earlier periods in 2009. For the nine months ended September 30, 2009, medical benefits expense was impacted by approximately \$51.0 million of net favorable development related to prior years. The net favorable prior year developments in the 2010 periods are primarily associated with the exit of our PFFS product on December 31, 2009. The unfavorable development recognized in the three months ended September 30, 2010 relating to earlier periods in 2010 was primarily due to higher than expected medical services that were not discernable until the impact became clearer over time as claim payments were processed. The net amount of prior period developments in the 2009 periods was primarily attributable to pricing assumptions, early durational effect favorability, the volatility associated with our new and small blocks of MA business, which were converted from the loss ratio methodology to the development factor methodology in 2009 (both methodologies are recognized methods for estimating claim reserves in accordance with actuarial standards of practice), the recovery by us of claim overpayments on our PFFS product that exceeded our estimates and better than expected demographic mix of membership. The factors impacting the changes in the determination of reserve balances discussed above were not discernable in advance. The impact became clearer over time as claim payments were processed and more complete claims information was obtained.

#### *Goodwill and Intangible Assets*

We review goodwill and intangible assets for potential impairment at least annually, or more frequently if events or changes in circumstances occur that may affect the estimated useful life or the recoverability of the remaining balance of goodwill or intangible assets. Events or changes in circumstances would include significant changes in membership, state funding, medical contracts and provider networks. We evaluate the potential impairment of goodwill and intangible assets using both the income and market approach. In doing so, we must make assumptions and estimates, such as the discount factor and peer benchmarking, in estimating fair values. While we believe these assumptions and estimates are appropriate, other assumptions and estimates could be applied and might produce significantly different results. An impairment loss is recognized for goodwill and intangible assets if the carrying value of such assets exceeds its fair value. We select the second quarter of each year for our annual impairment test, which generally coincides with the finalization of federal and state contract negotiations and our initial budgeting process. Our annual impairment test was completed during the third quarter of 2010. We assessed the book value of goodwill and other intangible assets and have determined that the fair value of our goodwill exceeds its carrying value, and as a result, there were no indications of additional impairment testing required as of September 30, 2010.

In addition, we have evaluated the intangible assets in connection with our PFFS exit on December 31, 2009, which primarily consisted of state licenses for the insurance companies that underwrote that line of business. As we continue to use these company licenses for other lines of business and the licenses have a market value, we determined that these assets have not been impaired as of September 30, 2010.



## Results of Operations

### Three and Nine Months Ended September 30, 2010 Compared to the Three and Nine Months Ended September 30, 2009

#### Summary of Financial Information:

The following tables set forth data from our Condensed Consolidated Statements of Operations, as well as other key data used in our results of operations discussion. Results for the interim periods presented are not necessarily indicative of results that may be expected for the entire year or any other interim period.

| Condensed Consolidated Statement<br>of Operations Data: | Three Months Ended September 30, |                | Nine Months Ended September 30, |                |
|---|----------------------------------|----------------|---------------------------------|----------------|
|   | 2010                             | 2009           | 2010                            | 2009           |
| Revenues:   |                                  |                |                                 |                |
| Premium   | \$ 1,385.9                       | \$ 1,666.0     | \$ 4,077.3                      | \$ 5,245.8     |
| Investment and other income                             | 2.3                              | 1.6            | 7.5                             | 8.4            |
| Total revenues  | <u>1,388.2</u>                   | <u>1,667.6</u> | <u>4,084.8</u>                  | <u>5,254.2</u> |
| Expenses:   |                                  |                |                                 |                |
| Medical benefits  | 1,147.1                          | 1,420.2        | 3,435.9                         | 4,477.2        |
| Selling, general and administrative                     | 161.7                            | 195.6          | 739.7                           | 682.6          |
| Depreciation and amortization                           | 6.1                              | 5.9            | 17.8                            | 17.5           |
| Interest  | 0.1                              | 0.0            | 0.2                             | 3.1            |
| Total expenses  | <u>1,315.0</u>                   | <u>1,621.7</u> | <u>4,193.6</u>                  | <u>5,180.4</u> |
| Income (loss) before income taxes                       | 73.2                             | 45.9           | (108.8)                         | 73.8           |
| Income tax expense (benefit)                            | 30.3                             | 17.3           | (29.3)                          | 45.1           |
| Net income (loss)                                       | <u>\$ 42.9</u>                   | <u>\$ 28.6</u> | <u>\$ (79.5)</u>                | <u>\$ 28.7</u> |
| Net income (loss) per common share:                     |                                  |                |                                 |                |
| Basic   | \$ 1.01                          | \$ 0.68        | \$ (1.88)                       | \$ 0.69        |
| Diluted   | \$ 1.00                          | \$ 0.68        | \$ (1.88)                       | \$ 0.68        |
| Consolidated MBR  | 82.8%                            | 85.2%          | 84.3%                           | 85.3%          |

#### Summary of Consolidated Financial Results:

##### Membership

| Membership:      | September 30, 2010 | June 30, 2010    | September 30, 2009 |
|------------------|--------------------|------------------|--------------------|
| Medicaid         | 1,328,000          | 1,328,000        | 1,322,000          |
| MA               | 116,000            | 115,000          | 240,000            |
| PDP              | 756,000            | 741,000          | 768,000            |
| Total Membership | <u>2,200,000</u>   | <u>2,184,000</u> | <u>2,330,000</u>   |

As of September 30, 2010, we served approximately 2,200,000 members; a decrease of 130,000 members from the 2,330,000 members we served as of September 30, 2009. The overall membership decrease was due primarily to our December 31, 2009 exit from our PFFS product, which accounted for 101,000 MA members as of September 30, 2009, as well as a decline in MA CCP and PDP membership. However, membership in our MA CCP segment increased slightly from 115,000 at June 30, 2010, which reflects the strengthening throughout 2010 of our sales process and results. The 2009 CMS Medicare marketing sanction, which was lifted in November 2009, made us ineligible to receive auto-assignments of low-income subsidy, dual-eligible beneficiaries into our PDP plans for January 2010 enrollment. We received auto-assignments of such members in subsequent months, although such assignments were below the level we typically experience in the month of January. However, membership increased from 741,000 at June 30, 2010, and we anticipate modest membership growth through the remainder of 2010, primarily driven by the auto-assignment of LIS dual-eligible beneficiaries. For 2011, we are targeting membership growth for both our MA and PDP segments.

### Premium Revenue

Premium revenue for the three months ended September 30, 2010 decreased \$280.1 million, or 16.8%, to \$1,385.9 million from \$1,666.0 million for the same period in the prior year. For the nine months ended September 30, 2010, premium revenues decreased \$1,168.5 million, or 22.3%, to \$4,077.3 million from approximately \$5,245.8 million for the same period in the prior year. The decrease in premium revenue is primarily attributable to the decline in membership in our PDP and MA segments, with the exit from our PFFS product accounting for the majority of MA segment premium reductions. In addition, the State of Georgia eliminated the Medicaid premium tax in October 2009, which reduced our premium by a commensurate amount. We became subject to a premium tax in July 2010 and received a proportionate rate increase. The premium tax rate as of July 2010 was lower than the rate in effect prior to October 2009.

### Investment and Other Income

Investment and other income for the three months ended September 30, 2010 increased \$0.7 million, or 43.8%, compared to the same period in the prior year. The increase is attributed to shifting our investment portfolio during the quarter from tax-exempt to taxable investments, which typically generates a higher yield, and from other income derived primarily from co-payments collected on member prescriptions and sales of prescriptions to non-members that can vary each period. For the nine months ended September 30, 2010, investment and other income decreased \$0.9 million, or 10.7%, compared to the same period in the prior year. The decrease was primarily due to reduced market rates on lower average cash and investment balances, partially offset by the increase in other income described above.

### Medical Benefits Expense

Medical benefits expense for the three months ended September 30, 2010 decreased \$273.1 million, or 19.2%, to \$1,147.1 million from \$1,420.2 million for the same period in the prior year. For the nine months ended September 30, 2010, medical benefits expense decreased \$1,041.3 million, or 23.3%, to \$3,435.9 million from \$4,477.2 million for the same period in the prior year. The decrease in medical benefits expense for both the three and nine months ended September 30, 2010 is primarily due to the exit from our PFFS product, the decline in membership and premiums, as well as improved performance in our PDP segment. The consolidated MBR was 82.8% and 85.2% for the three months ended September 30, 2010 and 2009, respectively. For the nine months ended September 30, 2010, the consolidated MBR was 84.3% compared to 85.3% for the same period in the prior year. The decline in MBR for the three and nine months ended September 30, 2010 compared to the same periods in the prior year is primarily due to the exit from our PFFS product, improved performance of our MA and PDP segments and the change in the premium tax assessment associated with the Georgia Medicaid program.

### Selling, General and Administrative Expense

Selling, general and administrative ("SG&A") expense includes aggregate costs related to the resolution of the previously disclosed governmental and Company investigations, such as: settlement accruals and related fair value accretion, legal fees and other similar costs; net of \$25.1 million and \$25.8 million of D&O insurance recoveries in the three and nine months ended September 30, 2010, respectively, related to the putative class action complaints. We believe it is appropriate to evaluate SG&A expense exclusive of these investigation-related and litigation resolution costs because they are not believed to be indicative of long-term business operations. A summary of these investigation-related resolution costs and a reconciliation of SG&A expense, including and excluding such costs, are presented below.

|  | <b>Three Months Ended September 30,</b> |             | <b>Nine Months Ended September 30,</b> |             |
|--|---|-------------|--|-------------|
|  | <b>2010</b>                             | <b>2009</b> | <b>2010</b>                            | <b>2009</b> |
| SG&A expense   | \$ 161.7                                | \$ 195.6    | \$ 739.7                               | \$ 682.6    |
| Adjustments:   |   |             |  |             |
| Litigation resolution costs  | (3.1)                                   | (0.5)       | (251.5)                                | (60.2)      |
| Investigation-related administrative costs, net of D&O insurance policy recovery | 10.5                                    | (9.0)       | 1.1                                    | (32.9)      |
| Net investigation-related and litigation resolution costs                        | 7.4                                     | (9.5)       | (250.4)                                | (93.1)      |
| Adjusted SG&A expense  | \$ 169.1                                | \$ 186.1    | \$ 489.3                               | \$ 589.5    |

Excluding the investigation-related and litigation resolution costs, our SG&A expense decreased by \$17.0 million, or 9.1%, and \$100.2 million, or 17.0%, during the three and nine months ended September 30, 2010, respectively, compared to the same periods in 2009. The decrease for both periods resulted from the exit of our PFFS product, the change in the premium tax assessment associated with the Georgia Medicaid program as well as gains in operating efficiency, offset in part by increased costs for MA CCP marketing and infrastructure investments and severance costs associated with our organizational realignment announced in the quarter.

Our SG&A expense as a percentage of revenue (“SG&A ratio”) was 11.6% for the three months ended September 30, 2010 compared to 11.7% for the same period in the prior year. For the nine months ended September 30, 2010, our SG&A ratio was 18.1% compared to 13.0% for the same period in the prior year. After excluding the investigation-related and litigation resolution costs, our SG&A ratio for the three and nine months ended September 30, 2010 was 12.2% and 12.0%, respectively, compared to 11.2% for both the three and nine months ended September 30, 2009. Our SG&A ratio increased for both the three and nine months ended September 30, 2010 mainly due to a lower revenue base in 2010 resulting from the exit from our PFFS product and lower MA CCP marketing costs in 2009 due to the CMS marketing sanction, partially offset by the factors reducing our SG&A expense discussed above. We will continue to evaluate our operations in order to achieve our long-term target of an administrative expense ratio in the low 10% range, excluding premium taxes. We anticipate making progress toward this target throughout 2011. However, we anticipate that our fourth quarter SG&A ratio will be seasonally higher due to Medicare enrollment marketing.

#### *Income Tax Expense (Benefit)*

Income tax expense for the three months ended September 30, 2010 was \$30.3 million compared to \$17.3 million for the same period in the prior year, with an effective tax rate of 41.3% and 37.6% for the three months ended September 30, 2010 and 2009, respectively. The income tax benefit on pre-tax loss for the nine months ended September 30, 2010 was \$29.3 million with an effective tax rate of 26.9%. Our effective income tax rate for the nine-months ended September 30, 2010 was impacted by limitations on the deductibility of certain administrative expenses associated with the resolution of investigation-related matters and certain executive compensation costs, partially offset by certain investigation-related costs that were originally believed to be non-deductible for tax purposes during 2009 that were ultimately identified as tax deductible in 2010. Our income tax expense on pre-tax income for the nine-months ended September 30, 2009 was \$45.1 million with an effective tax rate of 61.1%. Our effective tax rate on pre-tax income for the nine months ended September 30, 2009 was primarily attributed to non-deductible costs incurred in conjunction with resolving certain investigation-related matters.

#### *Net Income (Loss)*

Net income for the three months ended September 30, 2010 was \$42.9 million, compared to \$28.6 million for the same period in 2009. For the nine months ended September 30, 2010, the net loss was \$79.5 million compared to \$28.7 million of net income for the same period in 2009. Investigation-related and litigation resolution costs amounted to a benefit of \$5.0 million, net of tax, for the three months ended September 30, 2010 and an expense of \$6.1 million, net of tax, for the three months ended September 30, 2009. Excluding these investigation-related and litigation resolution costs, net income for the three months ended September 30, 2010 and 2009 was \$37.9 million and \$34.7 million, respectively. The increase in net income for the three months ended September 30, 2010 compared to the same period in the prior year was primarily the result of improvement in our overall MBR and reduction of SG&A expenses. Investigation-related and litigation resolution costs amounted to an expense of \$163.3 million and \$78.1 million, net of tax, for the nine months ended September 30, 2010 and 2009, respectively. Excluding these investigation-related and litigation resolution costs, net income for the nine months ended September 30, 2010 and 2009 was \$83.8 million and \$106.8 million, respectively. The decrease in net income for the nine months ended September 30, 2010 compared to the same period in the prior year was mainly the result of the loss of gross margin from the withdrawal of our PFFS product, offset partially by our overall MBR improvement and SG&A expense reduction.

**Reconciling Segment Results:**

The following table reconciles our reportable segment results with our income (loss) before income taxes, as reported under GAAP.

| Reconciling Segment Results Data: | Three Months Ended September 30, |                | Nine Months Ended September 30, |                |
|-----------------------------------|----------------------------------|----------------|---------------------------------|----------------|
|                                   | 2010                             | 2009           | 2010                            | 2009           |
| Gross Margin:                     |                                  |                |                                 |                |
| Medicaid                          | \$ 111.7                         | \$ 103.8       | \$ 331.4                        | \$ 345.1       |
| Medicare Advantage                | 70.4                             | 109.9          | 216.5                           | 380.8          |
| PDP                               | 56.6                             | 32.2           | 93.5                            | 42.7           |
| Total gross margin                | <u>238.7</u>                     | <u>245.9</u>   | <u>641.4</u>                    | <u>768.6</u>   |
| Investment and other income       | 2.3                              | 1.6            | 7.5                             | 8.4            |
| Other expenses                    | 167.8                            | 201.5          | 757.7                           | 703.1          |
| Income (loss) before income taxes | <u>\$ 73.2</u>                   | <u>\$ 46.0</u> | <u>\$ (108.8)</u>               | <u>\$ 73.9</u> |

**Medicaid Segment Results:**

| Medicaid Segment Results Data: | Three Months Ended September 30, |                 | Nine Months Ended September 30, |                 |
|--------------------------------|----------------------------------|-----------------|---------------------------------|-----------------|
|                                | 2010                             | 2009            | 2010                            | 2009            |
| Premium revenue                | \$ 854.9                         | \$ 814.1        | \$ 2,464.6                      | \$ 2,437.0      |
| Medical benefits expense       | 743.2                            | 710.3           | 2,133.2                         | 2,091.9         |
| Gross margin                   | <u>\$ 111.7</u>                  | <u>\$ 103.8</u> | <u>\$ 331.4</u>                 | <u>\$ 345.1</u> |

**Medicaid Membership:**

|              |                  |                  |
|--------------|------------------|------------------|
| Florida      | 418,000          | 412,000          |
| Georgia      | 548,000          | 527,000          |
| Other States | 362,000          | 383,000          |
|              | <u>1,328,000</u> | <u>1,322,000</u> |

|              |       |       |       |       |
|--------------|-------|-------|-------|-------|
| Medicaid MBR | 86.9% | 87.2% | 86.6% | 85.8% |
|--------------|-------|-------|-------|-------|

Medicaid premium revenue for the three months ended September 30, 2010 increased \$40.8 million to \$854.9 million from \$814.1 million for the same period in the prior year. Medicaid premium revenue for the nine months ended September 30, 2010 increased \$27.6 million to \$2,464.6 million from \$2,437.0 million for the same period in the prior year. The increase in premium revenue for both periods was mainly due to rate increases implemented in most markets during the third quarter and membership growth in Georgia, partially offset by the change in the premium tax assessment associated with the Georgia Medicaid program and the decrease in membership in New York. New York program rates were effective April 1, 2010, therefore we recognized a \$6.7 million benefit in the third quarter that was attributable to the second quarter impact of the retroactive rate action. Membership increased overall by approximately 6,000 members to 1,328,000 as of September 30, 2010, from 1,322,000 as of September 30, 2009.

Medicaid medical benefits expense for the three months ended September 30, 2010 increased \$32.9 million to \$743.2 million from \$710.3 million from the same period in the prior year due mainly to increased membership and the impact of unfavorable reserve development experienced in 2010. Medicaid medical benefits expense for the nine months ended September 30, 2010 increased \$41.3 million to \$2,133.2 million from \$2,091.9 million in the prior year due to the impact of favorable reserve development experienced in 2009 and medical cost inflation, partially offset by an improvement in MBR excluding the impact of prior period favorable reserve development experienced in 2009. The decrease in the Medicaid MBR for the three months ended September 30, 2010 was due to rate increases and medical cost initiatives, partially offset by the impact of the unfavorable reserve development experienced in 2010. The net unfavorable reserve development was mostly related to prior years and was primarily associated with provider and state customer agreements. The increase in Medicaid MBR for the nine months ended September 30, 2010 is mainly from the change in the Georgia premium tax assessment, premium increases during the past year that were below our medical cost trend and the impact of favorable reserve development experienced in 2009 that exceeded the favorable impact of the reserve development in 2010.

**Medicare Advantage Segment Results:**

| MA Segment Results Data: | Three Months Ended September 30, |          | Nine Months Ended September 30, |            |
|--------------------------|----------------------------------|----------|---------------------------------|------------|
|                          | 2010                             | 2009     | 2010                            | 2009       |
| Premium revenue          | \$ 331.3                         | \$ 660.0 | \$ 1,012.4                      | \$ 2,142.9 |
| Medical benefits expense | 260.9                            | 550.1    | 795.9                           | 1,762.1    |
| Gross margin             | \$ 70.4                          | \$ 109.9 | \$ 216.5                        | \$ 380.8   |
| MA Membership            | 116,000                          | 240,000  |                                 |            |
| MA MBR                   | 78.7%                            | 83.4%    | 78.6%                           | 82.2%      |

Our MA segment includes results from the PFFS product that we exited on December 31, 2009. MA premium revenue for the three months ended September 30, 2010 decreased \$328.7 million to \$331.3 million from \$660.0 million for the same period in the prior year. MA premium revenue for the nine months ended September 30, 2010 decreased \$1,130.5 million to \$1,012.4 million from \$2,142.9 million for the same period in the prior year. Membership decreased by approximately 124,000 members to 116,000 as of September 30, 2010, from 240,000 as of September 30, 2009. The decrease in MA premium revenue and membership was primarily attributable to the PFFS withdrawal and reduced MA CCP membership due to our inability to enroll new members during the 2009 CMS marketing sanction period. Correspondingly, MA gross margin for the three and nine months ended September 30, 2010 decreased by \$39.5 million and \$164.3 million, respectively, compared to the same periods in the prior year due to the decrease in premiums, partially offset by prior period favorable medical benefit reserve development related to the PFFS product. The decrease in the MA MBR for both the three and nine months ended September 30, 2010 was primarily related to the withdrawal of PFFS plans, which operated at an MBR above the segment average and the prior period favorable reserve development related to the PFFS product. We anticipate that the MBR will increase in 2011, absent the benefit experienced in 2010 related to the withdrawal of PFFS plans.

**Prescription Drug Plan Segment Results:**

| PDP Segment Results Data: | Three Months Ended September 30, |          | Nine Months Ended September 30, |          |
|---------------------------|----------------------------------|----------|---------------------------------|----------|
|                           | 2010                             | 2009     | 2010                            | 2009     |
| Premium revenue           | \$ 199.6                         | \$ 191.9 | \$ 600.3                        | \$ 665.9 |
| Medical benefits expense  | 143.0                            | 159.7    | 506.8                           | 623.2    |
| Gross margin              | \$ 56.6                          | \$ 32.2  | \$ 93.5                         | \$ 42.7  |
| PDP Membership            | 756,000                          | 768,000  |                                 |          |
| PDP MBR                   | 71.7%                            | 83.2%    | 84.4%                           | 93.6%    |

PDP premium revenue for the three months ended September 30, 2010 increased \$7.7 million to \$199.6 million from \$191.9 million for the same period in the prior year. PDP premium revenue increased during the three months ended September 30, 2010 due primarily to the decrease in the risk corridor payment to CMS. PDP premium revenue for the nine months ended September 30, 2010 decreased \$65.6 million to \$600.3 million from \$665.9 million for the same period in the prior year. The decrease in PDP premium revenue during the nine months ended September 30, 2010 was due primarily to a decline in membership. Membership decreased by approximately 12,000 members to 756,000 as of September 30, 2010 from 768,000 as of September 30, 2009 as a result of the 2009 CMS marketing sanction which made us ineligible to receive auto-assignments into our PDP plan in January 2010. However, membership increased from 741,000 at June 30, 2010, and we anticipate modest membership growth through the remainder of 2010, primarily driven by the auto-assignment of LIS, dual-eligible beneficiaries.

PDP MBR improved for both the three and nine months ended September 30, 2010 due to improved performance of the product. PDP gross margin for the three months ended September 30, 2010 increased \$24.4 million to \$56.6 million from \$32.2 million for the same period in the prior year. PDP gross margin for the nine months ended September 30, 2010 increased \$50.8 million to \$93.5 million from \$42.7 million for the same period in the prior year. The improvement in gross margin for both periods was due mainly to better overall performance of the Part D product, partially offset by the decrease in premiums. We will likely experience an increase in our PDP MBR in 2011.

## Liquidity and Capital Resources

### Overview

Each of our existing and anticipated sources of cash is impacted by operational and financial risks that influence the overall amount of cash generated and the capital available to us. For a further discussion of risks that can affect our liquidity, see “Risk Factors” in Part I – Item 1A included in our 2009 Form 10-K and in Part II – Item 1A of this Form 10-Q.

### Cash Positions

As of September 30, 2010, our consolidated cash and cash equivalents were approximately \$1,091.0 million, our consolidated investments were approximately \$119.5 million, our unregulated cash was approximately \$198.2 million and our unregulated investments were approximately \$2.7 million. As of December 31, 2009, our consolidated cash and cash equivalents were approximately \$1,158.1 million, our consolidated investments were approximately \$114.4 million, our unregulated cash was approximately \$117.6 million and our unregulated investments were approximately \$2.8 million.

During the three and nine months ended September 30, 2010, we received \$20.7 million and \$45.7 million, respectively, in dividends from our regulated subsidiaries, which increased our unregulated cash. We currently believe that we will be able to meet our known near-term monetary obligations and maintain sufficient liquidity to operate our business. However, one or more of our regulators could require one or more of our subsidiaries to maintain minimum levels of statutory net worth in excess of the amount required under the applicable state laws if the regulators were to determine that such a requirement were in the interest of our members. Further, there may be other potential adverse developments that could impede our ability to meet our obligations.

### Initiatives to Increase Our Unregulated Cash

We are pursuing alternatives to raise additional unregulated cash. Some of these initiatives include, but are not limited to, consideration of obtaining dividends from certain of our regulated subsidiaries to the extent that we are able to access any available excess capital and accessing the credit markets. However, we cannot provide any assurances that we will obtain applicable state regulatory approvals for additional dividends to our non-regulated subsidiaries by our regulated subsidiaries.

### Statutory Capital and Surplus

Each of our HMO and insurance subsidiaries must maintain minimum levels of statutory capital in an amount determined by statute, regulation or order by the state insurance commissioner. The minimum statutory net worth requirements differ by state and are generally based on a percentage of annualized premium, a percentage of annualized health care costs, a percentage of certain liabilities, a statutory minimum, or risk-based capital (“RBC”) requirements. The RBC requirements are based on guidelines established by the National Association of Insurance Commissioners and are administered by the states. Each HMO and insurance company must submit a report of its capital and surplus and RBC level, if applicable, to the state insurance department at the end of each calendar year. As of September 30, 2010, we believe our HMO and insurance subsidiaries are in compliance with all applicable statutory capital requirements and RBC requirements, where applicable.

### Credit Facility

We entered into a credit agreement on May 12, 2010, which was subsequently amended on May 25, 2010 (as amended, the “Credit Agreement”). The Credit Agreement provides for a \$65.0 million committed revolving credit facility that expires on November 12, 2011. Borrowings under the Credit Agreement may be used for general corporate purposes.

The Credit Agreement is guaranteed by us and our subsidiaries, other than our HMO and insurance subsidiaries. In addition, the Credit Agreement is secured by first priority liens on our personal property and the personal property of our subsidiaries, other than the personal property and equity interests of our HMO and insurance subsidiaries.

Borrowings designated by us as Alternate Base Rate borrowings bear interest at a rate per annum equal to (i) the greatest of (a) the Prime Rate (as defined in the Credit Agreement) in effect on such day; (b) the Federal Funds Effective Rate (as defined in the Credit Agreement) in effect on such day plus 1/2 of 1%; and (c) the Adjusted LIBO Rate (as defined in the Credit Agreement) for a one month interest period on such day plus 1%; plus (ii) 1.5%. Borrowings designated by us as Eurodollar borrowings bear interest at a rate per annum equal to the Adjusted LIBO Rate for the interest period in effect for such borrowing plus 2.5%.

The Credit Agreement includes negative covenants that limit certain of our activities, including restrictions on our ability to incur additional indebtedness, and financial covenants that require a minimum ratio of cash flow to total debt, a maximum ratio of total liabilities to consolidated net worth and a minimum level of statutory net worth for our HMO and insurance subsidiaries.

The Credit Agreement also contains customary representations and warranties that must be accurate in order for us to borrow under the Credit Agreement. In addition, the Credit Agreement contains customary events of default. If an event of default occurs and is continuing, we may be required to immediately repay all amounts outstanding under the Credit Agreement, and the commitments under the Credit Agreement may be terminated.

As of September 30, 2010, the credit facility has not been drawn upon and we remain in compliance with all covenants.

#### *Directors and Officers Insurance Recovery*

In August 2010, we entered into an agreement and release with the carriers of our D&O liability insurance relating to coverage we sought for claims relating to the previously disclosed government investigations and related litigation. We agreed to accept immediate settlement of \$32.5 million, of which \$7.4 million previously received under the policy and recorded in prior periods in satisfaction of the \$45.0 million face amount of the relevant D&O insurance policies and the carriers agreed to waive any rights they may have to challenge our coverage under the policies. The agreement and release did not include a \$10.0 million face amount policy we maintain for non-indemnifiable securities claims by directors and officers during the same time period and such policy is not affected by the agreement and release. Accordingly, we recorded the \$25.1 million and \$25.8 million during the three and nine months ended September 30, 2010, respectively, of insurance proceeds as a reduction to SG&A expenses at the time the agreement was executed. Of this amount, \$19.7 million was received as of September 30, 2010 and the remaining \$6.1 million was collected in October 2010. No additional recoveries with respect to such matters are expected under our insurance policies and all expenses incurred by us in the future for these matters will not be further reimbursed by our insurance policies. We currently maintain directors and officers liability insurance in the amount of \$175.0 million for other matters not addressed above.

#### *Auction Rate Securities*

As of September 30, 2010, all of our long-term investments were comprised of municipal note investments with an auction reset feature ("auction rate securities"). These auction rate securities are issued by various state and local municipal entities for the purpose of financing student loans, public projects and other activities; they carry an investment grade credit rating. Although auctions continue to fail, we believe we will be able to liquidate these securities without significant loss, and we currently believe these securities are not impaired, primarily due to government guarantees or municipal bond insurance and our ability and present intent to hold these securities until maturity or market stability is restored; however, it could take until the final maturity of the underlying securities to realize our investments' recorded value. In March and May 2010, auction rate securities in the amount of \$6.3 million and \$4.6 million, respectively, were called at par, at the option of the issuer. We currently have the ability and present intent to hold our auction rate securities until maturity or market stability is restored with respect to these securities.

## Overview of Cash Flow Activities

For the nine months ended September 30, 2010 and 2009 our cash flows are summarized as follows:

|   | Nine Months Ended September 30, |         |
|---|---------------------------------|---------|
|   | 2010                            | 2009    |
|   | (In millions)                   |         |
| Net cash (used in) provided by operating activities | \$ (72.0)                       | \$ 69.5 |
| Net cash (used in) provided by investing activities | (13.5)                          | 72.5    |
| Net cash provided by (used in) financing activities | 18.3                            | (152.7) |

*Cash (used in) provided by Operating Activities:* Because we generally receive premiums in advance of payments of claims for health care services, we maintain balances of cash and cash equivalents pending payment of claims. Our net loss for the nine months ended September 30, 2010 was \$79.5 million. Cash used in operations consisted of primarily a \$98.9 million pay down of medical benefits payable, primarily the result of claim payments in 2010 relating to the PFFS product that we exited on December 31, 2009, unearned premiums that decreased \$24.5 million and accounts payable and other accrued expenses that decreased \$43.6 million, partially offset by the \$19.0 million in D&O insurance proceeds collected during the third quarter.

*Cash (used in) provided by Investing Activities:* During the nine months ended September 30, 2010, investing activities consisted primarily of the purchases of additions to property and equipment totaling approximately \$16.2 million.

*Cash provided by (used in) Financing Activities:* Included in financing activities are funds held for the benefit of members, which increased approximately \$22.6 million as of September 30, 2010. These PDP member subsidies represent pass-through payments from government partners and are not accounted for in our results of operations since they represent payments to fund deductibles, co-payments and other member benefits for certain of our members that normally fluctuate.

## Contractual Obligations

In June 2010, we announced that we reached a Preliminary Settlement with the Civil Division to settle its inquiries for \$137.5 million. In August 2010, we reached an agreement with the Lead Plaintiffs on the material terms of a settlement to resolve the putative class action complaints filed against us for \$200.0 million. Both of these settlements stipulate contractual installment payments. For further information on these settlement agreements, please refer to "Financial Impact of Government Investigations and Litigation" discussed earlier in this Item 2. Other than these agreements, there have been no other material changes related to our contractual obligations from the information we provided in our 2009 Form 10-K.

## Item 3. Quantitative and Qualitative Disclosures about Market Risk.

As of September 30, 2010, we had cash and cash equivalents of \$1,091.0 million, investments classified as current assets of \$72.7 million, long-term investments of \$46.8 million and restricted investments on deposit for licensure of \$124.7 million. The short-term investments classified as current assets consist of highly liquid securities with maturities between three and twelve months and longer term bonds with floating interest rates that are considered available for sale. Long-term restricted assets consist of cash and cash equivalents deposited or pledged to state agencies in accordance with state rules and regulations. These restricted assets are classified as long term regardless of the contractual maturity date due to the long-term nature of the states' requirements. The restricted investments classified as long term are subject to interest rate risk and will decrease in value if market rates increase. Because of their short-term pricing nature, however, we would not expect the value of these investments to decline significantly as a result of a sudden change in market interest rates. Assuming a hypothetical and immediate 1.0% increase in market interest rates at September 30, 2010 the fair value of our fixed income short-term investments would increase by less than \$0.1 million. Similarly, a 1.0% decrease in market interest rates at September 30, 2010 would result in a decrease of the fair value of our short-term investments of less than \$0.8 million.

#### **Item 4. Controls and Procedures.**

##### ***Evaluation of Disclosure Controls and Procedures***

Our management carried out an evaluation required by Rule 13a-15 under the Securities Exchange Act of 1934, as amended (the “Exchange Act”) under the leadership and with the participation of our Chief Executive Officer (“CEO”) and Chief Financial Officer (“CFO”), of the effectiveness of our disclosure controls and procedures as defined in Rule 13a-15 under the Exchange Act (“Disclosure Controls”). Based on the evaluation, our CEO and CFO concluded that our Disclosure Controls were effective as of the end of the period covered by this 2010 Form 10-Q.

##### ***Changes in Internal Control Over Financial Reporting***

There has not been any change in our internal control over financial reporting (as defined in Rule 13a-15(f) of the Exchange Act) identified in connection with the evaluation required by Rule 13a-15(d) under the Exchange Act during the quarter ended September 30, 2010 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

## Part II – OTHER INFORMATION

### Item 1. Legal Proceedings.

Information relating to legal proceedings, including a description of the status of ongoing investigations, actions and lawsuits arising from, or consequential to, these investigations is discussed in our 2009 Form 10-K and our Form 10-Q for the first and second quarters of 2010. Set forth below are the material developments that occurred since the end of second quarter 2010.

#### *Government Investigations*

As previously disclosed, in October 2008, the Civil Division of the United States Department of Justice (the "Civil Division") informed us that as part of the pending civil inquiry, it is investigating four qui tam complaints filed by relators against us under the whistleblower provisions of the False Claims Act, 31 U.S.C. sections 3729-3733. Also as previously disclosed, on June 24, 2010, (i) the United States government filed its Notice of Election to Intervene in three of the qui tam matters, and (ii) we announced that we reached a preliminary agreement (the "Preliminary Settlement") with the Civil Division, the Civil Division of the United States Attorney's Office for the Middle District of Florida (the "USAO"), and the Civil Division of the United States Attorney's Office for the District of Connecticut to settle their pending inquiries. On June 25, 2010, the Federal Court lifted the seal in the three qui tam complaints in which the government had intervened. Those complaints are now publicly available. In October 2010, the USAO filed a motion in one of the *qui tam* matters seeking a temporary stay of discovery.

#### *Putative Class Action Complaints*

In April 2010, the Lead Plaintiffs in the putative class action complaints filed against us in 2007 entitled *Eastwood Enterprises, L.L.C. v. Farha, et al.* and *Hutton v. WellCare Health Plans, Inc. et al.*, filed their motion for class certification. On June 18, 2010, the USAO filed motions seeking to intervene and for a temporary stay of discovery of this matter. In July 2010, the Federal Court granted the United States' motions and ordered that discovery be stayed through December 2010.

On August 6, 2010, we reached agreement with the Lead Plaintiffs on the material terms of a settlement to resolve this matter. The terms of the settlement are being documented in a formal settlement agreement that will be subject to approval by the Federal Court following notice to all class members. The settlement provides that we will make cash payments to the class of \$52.5 million within thirty business days following the Federal Court's preliminary approval of the settlement and \$35.0 million by July 31, 2011. The settlement also provides that we will issue to the class tradable unsecured bonds having an aggregate face value of \$112.5 million, with a fixed coupon of 6% and a maturity date of December 31, 2016. The bonds shall also provide that, if we incur debt obligations in excess of \$425.0 million that are senior to the bonds, the bonds shall accelerate as to payment and be redeemed. The settlement has two further contingencies. First, it provides that if, within three years following the date of the settlement agreement, the Company is acquired or otherwise experiences a change in control at a share price of \$30.00 or more, we will pay to the class an additional \$25.0 million. Second, the settlement provides that we will pay to the class 25% of any sums we recover from Messrs. Farha, Behrens and/or Bereday as a result of claims arising from the same facts and circumstances that gave rise to this matter. We may terminate the settlement if a certain number or percentage of the class opt out of the settlement class. The settlement agreement will also provide that the settlement does not constitute an admission of liability by any party and such other terms as are customarily contained in settlement agreements of similar matters.

As a result of this settlement having been reached, our current estimate for the resolution of this matter is \$200.0 million. We have discounted the \$200.0 million liability for the resolution of this matter and accrued this amount at its estimated fair value, which amounted to approximately \$194.9 million at September 30, 2010. There can be no assurance that the settlement will be finalized and approved and the actual outcome of this matter may differ materially from the terms of the settlement.

#### *Derivative Lawsuits*

As previously disclosed, the United States District Court for the Middle District of Florida approved the Stipulation of Partial Settlement and granted our motion to dismiss the director defendants and realigned us as the plaintiff in the pending federal derivative action in July 2010. The case is now styled as *WellCare v. Farha, et al.* In July 2010, the Federal Court stayed discovery through December 2010. In August 2010, Messrs. Farha, Behrens and Bereday filed a notice of appeal in the United States Court of Appeals for the Eleventh Circuit (the "Court of Appeals"), which was dismissed for lack of jurisdiction in October 2010. The defendants have moved for reconsideration of the Court of Appeals' order of dismissal.

Also as previously disclosed, the Circuit Court for Hillsborough County, Florida approved the Stipulation of Partial Settlement and granted our motion to dismiss the director defendants and realigned us as the plaintiff in the pending state derivative action in June 2010. In July 2010, Mr. Farha filed a notice of appeal in this matter, which remains pending.

In October 2010, we filed a motion for leave to file an amended complaint against Mr. Farha in the State Court action and a new lawsuit in Federal Court against Messrs. Behrens and Bereday, stating claims for breach of contract and breach of their fiduciary duties.

#### **Item 1A. Risk Factors.**

Set forth below is an update of material changes to the risk factors disclosed in “Part I – Item 1A – Risk Factors” of our 2009 Form 10-K.

#### **Recently enacted health legislation is expected to bring about significant reform to the American health care system; and present challenges for our business that could have a material adverse effect on our results of operations and cash flows.**

In March 2010, President Obama signed the 2010 Acts. We believe these laws will bring about significant changes to the American health care system. While these measures are intended to expand the number of United States citizens covered by health insurance and make other coverage, delivery, and payment changes to the current health care system, the costs of implementing the 2010 Acts will be financed, in part, by future reductions in the payments made to Medicare providers.

Provisions of the 2010 Acts will become effective over the next several years. Several departments within the federal government will issue regulations and guidance on implementing the 2010 Acts. Because final rules and guidance on key aspects of the legislation have not yet been promulgated by the government regulators, the impact of the 2010 Acts is still unknown. We believe that revisions to the existing system may put pressure on operating results, decrease member benefits, and/or increase member premiums, particularly with respect to MA plans.

The 2010 Acts include a number of changes to the way MA plans will operate in the future such as: deriving premium payments based on quality scores, establishing minimum medical loss ratios and new taxes and assessments. As part of the health care reform legislation, MA payment benchmarks for 2011 were frozen at 2010 levels. Beginning in 2012, MA plan premiums will be tied to quality measures and based on a CMS “5-star rating system.” This rating system will allow an MA plan to receive an increase in certain premium rates. It is unknown whether these ratings will be geographically or demographically adjusted. The final methodology used in the determination of our quality score, which continues to be developed by CMS, could impact our ability to provide additional benefits and entice new members. Beginning in 2014, MA plans with medical loss ratios below the targets prescribed will be required to return premiums to CMS each year. Guidance on calculating the minimum medical loss ratio has not yet been determined. These rules will include defining which expenses should be classified as medical expense for the calculation, such as utilization management; which taxes, fees and assessments will be excluded from premium; the period over which the ratio will be calculated; and whether the calculation will be on a whole company or some type of disaggregated basis. Given the significance of this portion of the new legislation and the lack of definitive guidance from the respective government agencies, we are not able to project fully the impact of the minimum medical loss ratio on our operating results and cash flows.

The health reforms in the 2010 Acts present several challenges as well as opportunities for our Medicaid business. We anticipate that the reforms could significantly increase the number of citizens who are eligible to enroll in our Medicaid products. However, state budgets continue to be strained due to economic conditions and uncertain levels of federal financing for current populations. As a result, the effects of any potential future expansions are uncertain, making it difficult to determine whether the 2010 Acts will have a positive or negative impact on our Medicaid business.

The 2010 Acts also include an annual assessment on the insurance industry beginning in 2014. The legislation anticipates that the \$8 billion insurance industry assessment is likely to increase in subsequent years. Due to the lack of regulations and guidance, we are unable to project the impact this additional tax will have on our operating results and cash flows.

In 2009, as part of the American Recovery and Reinvestment Act, Congress increased the FMAP, temporarily increasing federal funding for state Medicaid programs. The policy rationale was to help relieve states' fiscal problems in the face of declining revenues and rising Medicaid enrollments due to the economic downturn. The enhanced FMAP was set to expire at the end of 2010. The Senate and House of Representatives have separately passed legislation extending additional enhanced FMAP funding through June 2011.

## Item 2. Unregistered Sales of Equity Securities and Use of Proceeds.

### *Recent Sales of Unregistered Securities*

We did not sell any securities in the three months ended September 30, 2010 that were not registered under the Securities Act of 1933, as amended.

### *Issuer Purchases of Equity Securities*

We do not have a stock repurchase program. However, during the quarter ended September 30, 2010, certain of our employees were deemed to have surrendered shares of our common stock to satisfy their withholding tax obligations associated with the vesting of shares of restricted common stock. The following table summarizes these repurchases:

| <b>Period</b>                                 | <b>Total Number<br/>of Shares<br/>Purchased(1)</b> | <b>Average<br/>Price Paid<br/>Per Share(1)</b> | <b>Total Number<br/>of Shares<br/>Purchased as<br/>Part of<br/>Publicly<br/>Announced<br/>Plans or<br/>Programs</b> | <b>Maximum<br/>Number of<br/>Shares that<br/>May Yet Be<br/>Purchased<br/>Under the<br/>Plans or<br/>Programs</b> |
|---|--|--|---|---|
| July 1, 2010 through July 30, 2010            | 3,521  | \$ 25.00 (2)                                   | N/A   | N/A   |
| August 1, 2010 through August 31, 2010        | 1,559  | \$ 26.45 (3)                                   | N/A   | N/A   |
| September 1, 2010 through September 30, 2010  | 4,277  | \$ 27.18 (4)                                   | N/A   | N/A   |
| Total during quarter ended September 30, 2010 | 9,357  | \$ 26.36 (5)                                   | N/A   | N/A   |

- (1) The number of shares purchased represents the number of shares of our common stock deemed surrendered by our employees to satisfy their withholding tax obligations due to the vesting of shares of restricted common stock. For the purposes of this table, we determined the average price paid per share based on the closing price of our common stock as of the date of the determination of the withholding tax amounts (i.e., the date that the shares of restricted stock vested). We do not currently have a stock repurchase program. We did not pay any cash consideration to repurchase these shares.
- (2) The weighted average price paid per share during the period was \$23.06.
- (3) The weighted average price paid per share during the period was \$26.67.
- (4) The weighted average price paid per share during the period was \$26.67.
- (5) The weighted average price paid per share during the period was \$25.30.

## Item 6. Exhibits.

Exhibits are incorporated herein by reference or are filed or furnished with this report as set forth in the Exhibit Index on page 40 hereof.



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## **FORM 10-Q**

**WELLCARE HEALTH PLANS, INC. - WCG**

**Filed: May 06, 2011 (period: March 31, 2011)**

Quarterly report which provides a continuing view of a company's financial position

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**UNITED STATES**  
**SECURITIES AND EXCHANGE COMMISSION**  
Washington, D.C. 20549  
**FORM 10-Q**

(Mark One)

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

For the quarterly period ended **March 31, 2011**  
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: **001-32209**

**WELLCARE HEALTH PLANS, INC.**

(Exact name of registrant as specified in its charter)

**Delaware**

(State or other jurisdiction of  
incorporation or organization)

**47-0937650**

(I.R.S. Employer  
Identification No.)

**8725 Henderson Road, Renaissance One  
Tampa, Florida**

(Address of principal executive offices)

**33634**

(Zip Code)

**(813) 290-6200**

(Registrant's telephone number, including area code)

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. 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 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 "smaller reporting company" in Rule 12b-2 of the Exchange Act

Large accelerated filer  Accelerated filer  Non-accelerated filer  Smaller reporting company   
(Do not check if a 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

As of May 4, 2011 there were 42,561,287 shares of the registrant's common stock, par value \$.01 per share, outstanding.

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# WELLCARE HEALTH PLANS, INC.

## TABLE OF CONTENTS

|  | <u>Page</u>        |
|--|--------------------|
| <b>Part I — FINANCIAL INFORMATION</b>  |                    |
| Item 1. Financial Statements   |                    |
| Condensed Consolidated Statements of Operations for the three months ended March 31, 2011 and 2010 (unaudited) | <a href="#">2</a>  |
| Condensed Consolidated Balance Sheets at March 31, 2011 (unaudited) and December 31, 2010                      | <a href="#">3</a>  |
| Condensed Consolidated Statements of Cash Flows for the three months ended March 31, 2011 and 2010 (unaudited) | <a href="#">4</a>  |
| Notes to Condensed Consolidated Financial Statements (unaudited)   | <a href="#">5</a>  |
| Item 2. Management’s Discussion and Analysis of Financial Condition and Results of Operations                  | <a href="#">20</a> |
| Item 3. Quantitative and Qualitative Disclosures About Market Risk   | <a href="#">36</a> |
| Item 4. Controls and Procedures  | <a href="#">36</a> |
| <b>Part II — OTHER INFORMATION</b>   |                    |
| Item 1. Legal Proceedings  | <a href="#">37</a> |
| Item 1A. Risk Factors  | <a href="#">39</a> |
| Item 2. Unregistered Sales of Equity Securities and Use of Proceeds  | <a href="#">39</a> |
| Item 5. Other Information  | <a href="#">40</a> |
| Item 6. Exhibits   | <a href="#">40</a> |
| Signatures   | <a href="#">41</a> |

**Part I — FINANCIAL INFORMATION****Item 1. Financial Statements.****WELLCARE HEALTH PLANS, INC.  
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS  
(Unaudited, in thousands, except per share data)**

|  | <b>Three Months Ended<br/>March 31,</b> |                  |
|--|---|------------------|
|  | <b>2011</b>                             | <b>2010</b>      |
| <b>Revenues:</b>                                 |   |                  |
| Premium (see Note 1)                             | \$ 1,472,416                            | \$ 1,353,458     |
| Investment and other income                      | 2,326                                   | 2,495            |
| Total revenues                                   | <u>1,474,742</u>                        | <u>1,355,953</u> |
| <b>Expenses:</b>                                 |   |                  |
| Medical benefits                                 | 1,245,040                               | 1,165,972        |
| Selling, general and administrative              | 169,243                                 | 163,593          |
| Medicaid premium taxes (see Note 1)              | 18,864                                  | 9,744            |
| Depreciation and amortization                    | 6,475                                   | 5,756            |
| Interest   | 77                                      | 10               |
| Total expenses                                   | <u>1,439,699</u>                        | <u>1,345,075</u> |
| Income before income taxes                       | 35,043                                  | 10,878           |
| Income tax expense                               | 13,713                                  | 4,460            |
| Net income                                       | <u>\$ 21,330</u>                        | <u>\$ 6,418</u>  |
| <b>Net income per common share (see Note 1):</b> |   |                  |
| Basic  | \$ 0.50                                 | \$ 0.15          |
| Diluted  | \$ 0.50                                 | \$ 0.15          |

*See notes to unaudited condensed consolidated financial statements.*

**WELLCARE HEALTH PLANS, INC.**  
**CONDENSED CONSOLIDATED BALANCE SHEETS**  
(In thousands, except share data)

|  | March 31,<br>2011 | December 31,<br>2010 |
|--|-------------------|----------------------|
|  | (Unaudited)       |                      |
| <b>Assets</b>  |                   |                      |
| Current Assets:  |                   |                      |
| Cash and cash equivalents  | \$ 1,232,918      | \$ 1,359,548         |
| Investments  | 201,894           | 108,788              |
| Premium receivables, net   | 190,182           | 127,796              |
| Funds held for the benefit of members  | —                 | 33,182               |
| Income taxes receivable  | 16,838            | 9,973                |
| Prepaid expenses and other current assets, net   | 117,815           | 114,492              |
| Deferred income tax asset  | 42,963            | 61,392               |
| Total current assets   | 1,802,610         | 1,815,171            |
| Property, equipment and capitalized software, net  | 75,980            | 76,825               |
| Goodwill   | 111,131           | 111,131              |
| Other intangible assets, net   | 11,045            | 11,428               |
| Long-term investments  | 83,717            | 62,931               |
| Restricted investments   | 105,812           | 107,569              |
| Deferred income tax asset  | 55,188            | 58,340               |
| Other assets   | 3,726             | 3,898                |
| Total Assets   | \$ 2,249,209      | \$ 2,247,293         |
| <b>Liabilities and Stockholders' Equity</b>  |                   |                      |
| Current Liabilities:   |                   |                      |
| Medical benefits payable   | \$ 790,624        | \$ 742,990           |
| Unearned premiums  | 84,532            | 67,383               |
| Accounts payable   | 7,629             | 8,284                |
| Other accrued expenses and liabilities   | 152,348           | 199,033              |
| Current portion of amounts accrued related to investigation resolution   | 68,799            | 121,406              |
| Other payables to government partners  | 52,179            | 46,605               |
| Funds held for the benefit of members  | 4,624             | —                    |
| Total current liabilities  | 1,160,735         | 1,185,701            |
| Amounts accrued related to investigation resolution  | 218,274           | 216,136              |
| Other liabilities  | 12,546            | 13,410               |
| Total liabilities  | 1,391,555         | 1,415,247            |
| Commitments and contingencies (see Note 6)   | —                 | —                    |
| Stockholders' Equity:  |                   |                      |
| Preferred stock, \$0.01 par value (20,000,000 authorized, no shares issued or outstanding)   | —                 | —                    |
| Common stock, \$0.01 par value (100,000,000 authorized, 42,557,404 and 42,541,725 shares issued and outstanding at March 31, 2011 and December 31, 2010, respectively) | 426               | 425                  |
| Paid-in capital  | 432,810           | 428,818              |
| Retained earnings  | 426,442           | 405,112              |
| Accumulated other comprehensive loss   | (2,024)           | (2,309)              |
| Total stockholders' equity   | 857,654           | 832,046              |
| Total Liabilities and Stockholders' Equity   | \$ 2,249,209      | \$ 2,247,293         |

See notes to unaudited condensed consolidated financial statements.

**WELLCARE HEALTH PLANS, INC.**  
**CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS**  
(Unaudited, in thousands)

|   | Three Months Ended March |                     |
|---|--------------------------|---------------------|
|   | 31,                      |                     |
|   | 2011                     | 2010                |
| Cash from (used in) operating activities:                                     |                          |                     |
| Net income  | \$ 21,330                | \$ 6,418            |
| Adjustments to reconcile net income to net cash used in operating activities: |                          |                     |
| Depreciation and amortization   | 6,475                    | 5,756               |
| Equity-based compensation expense   | 4,849                    | 1,142               |
| Deferred taxes, net   | 21,581                   | 16,721              |
| Changes in operating accounts:  |                          |                     |
| Premium receivables, net  | (62,386)                 | 23,781              |
| Prepaid expenses and other current assets, net                                | (3,323)                  | (2,985)             |
| Medical benefits payable  | 47,634                   | (95,690)            |
| Unearned premiums   | 17,149                   | (90,353)            |
| Accounts payables and other accrued expenses                                  | (43,475)                 | (18,466)            |
| Other payables to government partners   | 5,574                    | 4,547               |
| Amounts accrued related to investigation resolution                           | (50,469)                 | 511                 |
| Income taxes, net   | (8,012)                  | (14,401)            |
| Other, net  | (869)                    | (7,525)             |
| Net cash used in operating activities   | <u>(43,942)</u>          | <u>(170,544)</u>    |
| Cash from (used in) investing activities:                                     |                          |                     |
| Purchases of investments  | (198,305)                | (117)               |
| Proceeds from sale and maturities of investments                              | 85,043                   | 12,322              |
| Purchases of restricted investments   | (4,012)                  | (289)               |
| Proceeds from maturities of restricted investments                            | 5,601                    | 368                 |
| Additions to property, equipment and capitalized software, net                | (8,715)                  | (4,235)             |
| Net cash (used in) provided by investing activities                           | <u>(120,388)</u>         | <u>8,049</u>        |
| Cash from (used in) financing activities:                                     |                          |                     |
| Proceeds from option exercises and other                                      | 1,034                    | 770                 |
| Purchase of treasury stock  | (744)                    | (3,030)             |
| Payments on capital leases  | (396)                    | (58)                |
| Funds held for the benefit of members   | 37,806                   | 34,019              |
| Net cash provided by financing activities                                     | <u>37,700</u>            | <u>31,701</u>       |
| Cash and cash equivalents:  |                          |                     |
| Decrease during period  | (126,630)                | (130,794)           |
| Balance at beginning of year  | 1,359,548                | 1,158,131           |
| Balance at end of period  | <u>\$ 1,232,918</u>      | <u>\$ 1,027,337</u> |
| <b>SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION:</b>                     |                          |                     |
| Cash paid for taxes   | <u>\$ 446</u>            | <u>\$ 8,161</u>     |
| Cash paid for interest  | <u>\$ 74</u>             | <u>\$ 7</u>         |
| Equipment acquired through capital leases                                     | <u>\$ —</u>              | <u>\$ 8,411</u>     |

*See notes to unaudited condensed consolidated financial statements.*

**WELLCARE HEALTH PLANS, INC.**  
**NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS**  
**(Unaudited, in thousands, except member, per share and share data)**

**1. ORGANIZATION, BASIS OF PRESENTATION AND SIGNIFICANT ACCOUNTING POLICIES**

WellCare Health Plans, Inc., a Delaware corporation (the "Company," "we," "us," or "our"), provides managed care services exclusively to government-sponsored health care programs, serving approximately 2,383,000 members as of March 31, 2011. Through our licensed subsidiaries, as of March 31, 2011, we operate our Medicaid health plans in Florida, Georgia, Hawaii, Illinois, Missouri, New York and Ohio, and our Medicare Advantage ("MA") coordinated care plans ("CCPs") in Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Louisiana, Missouri, New Jersey, New York, Ohio and Texas. We also operate a stand-alone Medicare prescription drug plan ("PDP") in 49 states and the District of Columbia. We exited the Medicare private fee-for-service ("PFFS") program on December 31, 2009.

***Basis of Presentation & Use of Estimates***

The accompanying unaudited condensed consolidated interim financial statements should be read in conjunction with the consolidated financial statements and notes thereto for the fiscal year ended December 31, 2010 included in our Annual Report on Form 10-K ("2010 Form 10-K"), filed with the United States Securities and Exchange Commission (the "SEC") in February 2011. In the opinion of management, the interim financial statements reflect all normal recurring adjustments that we consider necessary for the fair presentation of our financial position, results of operations and cash flows for the interim periods presented. The interim financial statements included herein have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP") and with the instructions to Form 10-Q and Article 10 of Regulation S-X. Accordingly, certain information and footnote disclosures normally included in financial statements prepared in accordance with GAAP have been condensed or omitted. The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the condensed consolidated financial statements and accompanying notes. These estimates are based on knowledge of current events and anticipated future events and accordingly, actual results may differ from those estimates. Results for the interim periods presented are not necessarily indicative of results that may be expected for the entire year or any other interim period. Certain items in our financial statements have been reclassified from their prior year classifications to conform to our current year presentation. We have evaluated all material events subsequent to the date of these financial statements.

***Significant Accounting Policies***

***Net Income per Share***

We compute basic net income per common share on the basis of the weighted-average number of unrestricted common shares outstanding. Diluted net income per common share is computed on the basis of the weighted-average number of unrestricted common shares outstanding plus the dilutive effect of outstanding stock options, restricted shares and restricted stock units using the treasury stock method. The following table presents the calculation of net income per common share — basic and diluted:

|   | Three Months Ended<br>March 31, |            |
|---|---------------------------------|------------|
|   | 2011                            | 2010       |
| <b>Numerator:</b>   |                                 |            |
| Net income  | \$ 21,330                       | \$ 6,418   |
| <b>Denominator:</b>   |                                 |            |
| Weighted-average common shares outstanding — basic                            | 42,621,908                      | 42,193,662 |
| Dilutive effect of:   |                                 |            |
| Unvested restricted stock, restricted stock units and performance stock units | 280,073                         | 360,043    |
| Stock options   | 138,548                         | 153,536    |
| Weighted-average common shares outstanding — diluted                          | 43,040,529                      | 42,707,241 |
| Net income per common share:  |                                 |            |
| Basic   | \$ 0.50                         | \$ 0.15    |
| Diluted   | \$ 0.50                         | \$ 0.15    |

For the three months ended March 31, 2011 and 2010, certain options to purchase common stock were not included in the calculation of diluted net income per common share because their exercise prices were greater than the average market price of our common stock for the period and, therefore, the effect would be anti-dilutive. For the three months ended March 31, 2011, 142,153 restricted equity awards and 294,626 options with exercise prices ranging from \$28.27 to \$90.52 were excluded from diluted weighted-average common shares outstanding. For the three months ended March 31, 2010, approximately 119,356 restricted equity awards as well as 1,165,606 options with exercise prices ranging from \$24.17 to \$91.64 per share were excluded from diluted weighted-average common shares outstanding.

#### *Premium Revenue Recognition*

We receive premiums from state and federal agencies for the members that are assigned to, or have selected, us to provide health care services under Medicaid and Medicare. The premiums we receive for each member vary according to the specific government program and are generally determined at the beginning of the contract period. These premiums are subject to adjustment throughout the term of the contract by CMS and the states, although such adjustments are typically made at the commencement of each new contract renewal period.

Our Medicaid contracts with state governments are generally multi-year contracts subject to annual renewal provisions. Our Medicare Advantage and PDP contracts with the Centers for Medicare & Medicaid Services (“CMS”) generally have terms of one year.

In most cases we receive premiums in advance of providing services, and we recognize premium revenues in the period in which we are obligated to provide services to our members. We are paid generally in the month in which we provide services. Premiums are billed monthly for coverage in the following month and are recognized as revenue in the month for which insurance coverage is provided. Premiums collected in advance of the period in which we are obligated to provide services to our members are deferred and reported as Unearned premiums in the accompanying Condensed Consolidated Balance Sheets and amounts that have not been received by the end of the period remain on the Condensed Consolidated Balance Sheets classified as Premium receivables, net.

We routinely monitor the collectability of specific accounts, the aging of receivables and historical retroactivity trends, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. We estimate, on an ongoing basis, the amount of member billings that may not be fully collectible or that will be returned based on historical collection experience, retroactive membership adjustments, anticipated or actual, compliance with requirements for certain contracts to expend a minimum percentage of premiums on eligible medical expense, and other factors. An allowance is established for the estimated amount that may not be collectible and a liability is established for premium expected to be returned. The allowance has not been significant to premium revenue.

Premium payments that we receive are based upon eligibility lists produced by the government. We verify these lists to determine whether we have been paid for the correct premium category and program. From time to time, the states or CMS require us to reimburse them for premiums that we received based on an eligibility list that a state, CMS or we later discover, through our audits or otherwise, contains individuals who were not eligible for any government-sponsored program or belong to a different plan other than ours. The verification and subsequent membership changes may result in additional amounts due to us or we may owe premiums back to the government. The amounts receivable or payable identified by us through reconciliation and verification of agency eligibility lists relate to current and prior periods. The amounts receivable from government agencies for reconciling items were \$11,925 and \$270 at March 31, 2011 and December 31, 2010, respectively, and are included in Premium receivables, net, on our Condensed Consolidated Balance Sheets. The amounts due to government agencies for reconciling items were \$48,645 and \$63,289 at March 31, 2011 and December 31, 2010, respectively, and are included in Other accrued expenses and liabilities on our Condensed Consolidated Balance Sheets. We record adjustments to revenues based on member retroactivity. These adjustments reflect changes in the number and eligibility status of enrollees subsequent to when revenue was billed. We estimate the amount of outstanding retroactivity adjustments each period and adjust premium revenue accordingly; if appropriate, the estimates of retroactivity adjustments are based on historical trends, premiums billed, the volume of member and contract renewal activity and other information. Changes in member retroactivity adjustment estimates had a minimal impact on premiums recorded during the periods presented. Our government contracts establish monthly rates per member that may be adjusted based on member demographics such as age, working status or medical history.

### *Risk-Adjusted Premiums*

CMS employs a risk-adjustment model to determine the premium amount it pays for each member. This model apportions premiums paid to all MA plans according to the health status of each beneficiary enrolled. As a result, our CMS monthly premium payments per member may change materially, either favorably or unfavorably. The CMS risk-adjustment model pays more for Medicare members with predictably higher costs. Diagnosis data from inpatient and ambulatory treatment settings are used to calculate the risk-adjusted premiums we receive. We collect claims and encounter data and submit the necessary diagnosis data to CMS within prescribed deadlines. After reviewing the respective submissions, CMS establishes the premium payments to MA plans generally at the beginning of the calendar year, and then adjusts premium levels on two separate occasions on a retroactive basis. The first retroactive adjustment for a given fiscal year generally occurs during the third quarter of such fiscal year. This initial settlement (the "Initial CMS Settlement") represents the updating of risk scores for the current year based on the severity of claims incurred in the prior fiscal year. CMS then issues a final retroactive risk-adjusted premium settlement for that fiscal year in the following year (the "Final CMS Settlement"). We reassess the estimates of the Initial CMS Settlement and the Final CMS Settlement each reporting period and any resulting adjustments are made to MA premium revenue.

We develop our estimates for risk-adjusted premiums utilizing historical experience and predictive models as sufficient member risk score data becomes available over the course of each CMS plan year. Our models are populated with available risk score data on our members. Risk premium adjustments are based on member risk score data from the previous year. Risk score data for members who entered our plans during the current plan year, however, is not available for use in our models; therefore, we make assumptions regarding the risk scores of this subset of our member population. All such estimated amounts are periodically updated as additional diagnosis code information is reported to CMS and adjusted to actual amounts when the ultimate adjustment settlements are either received from CMS or we receive notification from CMS of such settlement amounts.

As a result of the variability of factors that determine such estimates, including plan risk scores, the actual amount of CMS retroactive payment could be materially more or less than our estimates. Consequently, our estimate of our plans' risk scores for any period, and any resulting change in our accrual of MA premium revenues related thereto, could have a material adverse effect on our results of operations, financial position and cash flows. Historically, we have not experienced significant differences between the amounts that we have recorded and the revenues that we ultimately receive. The data provided to CMS to determine the risk score is subject to audit by CMS even after the annual settlements occur. These audits may result in the refund of premiums to CMS previously received by us. While our experience to date has not resulted in a material refund, this refund could be significant in the future, which would reduce our premium revenue in the year that CMS determines repayment is required.

### Medical Benefits Payable and Expense

The cost of medical benefits is recognized in the period in which services are provided and includes an estimate of the cost of incurred but not reported (“IBNR”) medical benefits. Medical benefits payable has two main components: direct medical expenses and medically-related administrative costs. Direct medical expenses include amounts paid or payable to hospitals, physicians and providers of ancillary services, such as laboratories and pharmacies. Medically-related administrative costs include items such as case and disease management, utilization review services, quality assurance and on-call nurses, which are recorded in Selling, general, and administrative expense. Medical benefits payable on our Consolidated Balance Sheets represents amounts for claims fully adjudicated awaiting payment disbursement and estimates for IBNR claims. The following table provides a reconciliation of the total medical benefits payable balances as of March 31, 2011 and December 31, 2010:

|                                       | <b>March 31,<br/>2011</b> | <b>% of<br/>Total</b> | <b>December 31,<br/>2010</b> | <b>% of<br/>Total</b> |
|---------------------------------------|---------------------------|-----------------------|------------------------------|-----------------------|
|                                       | (in millions)             |                       | (in millions)                |                       |
| Claims adjudicated, but not yet paid  | \$ 78,067                 | 10%                   | \$ 50,879                    | 7%                    |
| IBNR                                  | 712,557                   | 90%                   | 692,111                      | 93%                   |
| <b>Total medical benefits payable</b> | <b>\$ 790,624</b>         |                       | <b>\$ 742,990</b>            |                       |

The medical benefits payable estimate has been, and continues to be, our most significant estimate included in our financial statements. We historically have used and continue to use a consistent methodology for estimating our medical benefits expense and medical benefits payable. Our policy is to record management’s best estimate of medical benefits payable based on the experience and information available to us at the time. This estimate is determined utilizing standard actuarial methodologies based upon historical experience and key assumptions consisting of trend factors and completion factors using an assumption of moderately adverse conditions, which vary by business segment. These standard actuarial methodologies include using, among other factors, contractual requirements, historic utilization trends, the interval between the date services are rendered and the date claims are paid, denied claims activity, disputed claims activity, benefits changes, expected health care cost inflation, seasonality patterns, maturity of lines of business and changes in membership.

Changes in medical benefits payable estimates are primarily the result of obtaining more complete claims information and medical expense trend data over time. Volatility in members’ needs for medical services, provider claims submissions and our payment processes result in identifiable patterns emerging several months after the causes of deviations from assumed trends occur. Since our estimates are based upon per-member per-month (“PMPM”) claims experience, changes cannot typically be explained by any single factor, but are the result of a number of interrelated variables, all of which influence the resulting medical cost trend. Differences in our financial statements between actual experience and estimates used to establish the liability, which we refer to as prior period developments, are recorded in the period when such differences become known and have the effect of increasing or decreasing the reported medical benefits expense in such periods.

Medical benefits expense for the three months ended March 31, 2011, was impacted by approximately \$51,038 of net favorable development related to prior years. For the three months ended March 31, 2010, medical benefits expense was impacted by approximately \$4,592 of net favorable development related to prior years. The net favorable prior year development in 2011 results primarily from the difference between actual medical utilization compared to original assumptions and prior year claims estimates being settled for amounts that are different than originally anticipated. The net amount of prior period developments in the 2010 was primarily attributable to the reduction of the provision for moderately adverse conditions resulting from the exit of the PFFS product on December 31, 2009. The factors impacting the changes in the determination of medical benefits payable discussed above were not discernable in advance. The impact became clearer over time as claim payments were processed and more complete claims information was obtained.

### Medicaid Premium Taxes

Certain state agencies place an assessment or tax on Medicaid premiums, which is included in the premium rates established in the Medicaid contracts with each state agency and recorded as a component of revenue, as well as administrative expense, when incurred.

In October 2009, the State of Georgia stopped assessing taxes on Medicaid premiums remitted to us, which resulted in an equal reduction to Premium revenues and Medicaid premium taxes. However, effective July 1, 2010, the State of Georgia began assessing premium taxes again on Medicaid premiums. Therefore, from July 1, 2010 through March 31, 2011, we were assessed and remitted taxes on premiums in Georgia, Hawaii, Missouri, New York and Ohio. Medicaid premium taxes incurred were \$18,864 and \$9,744 for the three months ended March 31, 2011 and 2010, respectively.

### *Income Taxes*

On a quarterly basis, our tax liability is estimated based on enacted tax rates, estimates of book-to-tax differences in income, and projections of income that will be earned in each taxing jurisdiction. Deferred tax assets and liabilities are recognized for the estimated future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax basis. Deferred tax assets and liabilities are measured using tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. A valuation allowance is recognized when, based on available evidence, it is more likely than not that the deferred tax assets may not be realized. After tax returns for the applicable year are filed, the estimated tax liability is adjusted to the actual liability per the filed state and Federal tax returns. Historically, we have not experienced significant differences between our estimates of tax liability and our actual tax liability.

We sometimes face challenges from state and Federal tax authorities regarding the amount of taxes due. Positions taken on the tax returns are evaluated and benefits are recognized only if it is more likely than not that the position will be sustained on audit. Based on our evaluation of tax positions, we believe that potential tax exposures have been recorded appropriately. In addition, we are periodically audited by state and Federal taxing authorities and these audits can result in proposed assessments. We believe that our tax positions comply with applicable tax law and, as such, will vigorously defend our positions on audit. We believe that we have adequately provided for any reasonable foreseeable outcome related to these matters. Although the ultimate resolution of these audits may require additional tax payments, it is not anticipated that any additional tax payments would have a material impact to our results of operations or cash flows.

### *Goodwill and Intangible Assets*

We review goodwill and intangible assets for impairment at least annually, or more frequently if events or changes in our business climate occur that may potentially affect the estimated useful life or the recoverability of the remaining balance of goodwill or intangible assets. Events or changes in circumstances would include significant changes in membership, state funding, medical contracts and provider networks. We select the second quarter of each year for our annual impairment test, which generally coincides with the finalization of federal and state contract negotiations and our initial budgeting process, and complete our impairment testing during the third quarter of each year. As of our last testing date in 2010, we assessed the book value of goodwill and other intangible assets and determined that the fair value of these assets exceeds its carrying value and noted no indications that would require additional impairment testing as of March 31, 2011.

### *Recently Issued Accounting Standards*

In December 2010, the Financial Accounting Standards Board (the "FASB") issued new guidance on business combinations to clarify that if a public entity presents comparative financial statements, the entity should disclose revenue and earnings of the combined entity as though the business combination that occurred during the current year had occurred as of the beginning of the prior annual reporting period and to include a description of the nature and amount of material, nonrecurring pro forma adjustments directly attributable to the business combination included in the reported pro forma revenue and earnings. This new guidance is effective prospectively for business combinations for which the acquisition date is on, or after, the beginning of the first annual reporting period beginning on or after December 15, 2010. Any future business combinations will be accounted for under this guidance. The adoption of this topic is not expected to have a material effect on our consolidated financial statements.

In December 2010, the FASB issued accounting guidance clarifying the requirement to test for goodwill impairment when the carrying amount of a reporting unit exceeds its fair value. Under this guidance, if the carrying amount of a reporting unit is zero or negative, an entity must assess whether any adverse qualitative factors exist that would indicate that goodwill impairment, more likely than not, exists. If it is determined that goodwill impairment would, more likely than not, be triggered, additional testing to determine whether goodwill has actually been impaired would be required and the amount of such impairment, if any, would accordingly be determined. This guidance is effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. The adoption of this topic is not expected to have a material effect on our consolidated financial statements.

We have reviewed all other recently issued accounting standards in order to determine their effects, if any, on our results of operations, financial position and cash flows. Based on that review, none of these pronouncements are expected to have a significant affect on our financial statements.

## 2. SEGMENT REPORTING

Reportable operating segments are defined as components of an enterprise for which discrete financial information is available and evaluated on a regular basis by the chief operating decision-maker to determine how resources should be allocated to an individual segment and to assess performance of those segments. Accordingly, we have three reportable segments within our two main business lines: Medicaid, MA and PDP. The PFFS product that we exited on December 31, 2009 is reported within the MA segment.

### *Medicaid*

Medicaid was established to provide medical assistance to low-income and disabled persons. It is state operated and implemented, although it is funded and regulated by both the state and federal governments. Our Medicaid segment includes plans for beneficiaries of Temporary Assistance for Needy Families (“TANF”), Supplemental Security Income (“SSI”), Aged Blind and Disabled (“ABD”) and state-based programs that are not part of the Medicaid program, such as Children’s Health Insurance Programs (“CHIPs”) and Family Health Plus (“FHP”) for qualifying families who are not eligible for Medicaid because they exceed the applicable income thresholds. TANF generally provides assistance to low-income families with children; ABD and SSI generally provide assistance to low-income aged, blind or disabled individuals.

### *Medicare*

Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons with a variety of hospital, medical insurance and prescription drug benefits.

### *Medicare Advantage*

Our MA segment consists of MA plans, which, following our exit from the PFFS product on December 31, 2009, is comprised of CCPs. MA is Medicare’s managed care alternative to original Medicare fee-for-service (“Original Medicare”), which provides individuals standard Medicare benefits directly through CMS. CCPs are administered through health maintenance organizations (“HMOs”) and generally require members to seek health care services and select a primary care physician from a network of health care providers. In addition, we offer Medicare Part D coverage, which provides prescription drug benefits, as a component of our MA plans.

As part of our MA segment, we continue to administer our expired PFFS plans, which include processing claims payments as well as providing member and provider services, for health care services provided prior to our exit from the PFFS program on December 31, 2009. As of March 31, 2011, the remaining medical benefits payable related to the PFFS program is not material relative to the total Medical benefits payable.

### *Prescription Drug Plans*

We offer stand-alone Medicare Part D coverage to Medicare-eligible beneficiaries in our PDP segment. The Medicare Part D prescription drug benefit is supported by risk sharing with the federal government through risk corridors designed to limit the losses and gains of the drug plans and by reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for risk factor payments. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries. The Part D program offers national in-network prescription drug coverage that is subject to limitations in certain circumstances.

We allocate goodwill, but no other assets or liabilities, or investment and other income, or any other expenses to our reportable operating segments. A summary of financial information for our reportable operating segments as well as a reconciliation to Income before income taxes is presented in the table below.

|                                | Three Months Ended<br>March 31, |                  |
|--------------------------------|---------------------------------|------------------|
|                                | 2011                            | 2010             |
| Premium revenue:               |                                 |                  |
| Medicaid                       | \$ 855,843                      | \$ 809,033       |
| Medicare Advantage             | 354,645                         | 351,083          |
| PDP                            | 261,928                         | 193,342          |
| Total premium revenue          | <u>1,472,416</u>                | <u>1,353,458</u> |
| Medical benefits expense:      |                                 |                  |
| Medicaid                       | 703,710                         | 701,779          |
| Medicare Advantage             | 277,029                         | 276,175          |
| PDP                            | 264,301                         | 188,018          |
| Total medical benefits expense | <u>1,245,040</u>                | <u>1,165,972</u> |
| Gross margin:                  |                                 |                  |
| Medicaid                       | 152,133                         | 107,254          |
| Medicare Advantage             | 77,616                          | 74,908           |
| PDP                            | (2,373)                         | 5,324            |
| Total gross margin             | <u>227,376</u>                  | <u>187,486</u>   |
| Investment and other income    | 2,326                           | 2,495            |
| Other expenses                 | (194,659)                       | (179,103)        |
| Income before income taxes     | <u>\$ 35,043</u>                | <u>\$ 10,878</u> |

### 3. EQUITY-BASED COMPENSATION

Equity-based compensation expense is calculated based on awards ultimately expected to vest. The compensation expense recorded related to our equity-based compensation awards, which correspondingly also increased Paid-in capital, for the three months ended March 31, 2011 and 2010 was \$4,849 and \$1,142, respectively.

Under the 2004 Equity Incentive Plan, we granted a performance share award to a former executive, of which the vesting and the amount of shares to be awarded were contingent upon achievement of an earnings per share target over three- and five-year performance periods. The earnings per share target for the first performance period was achieved. However, in accordance with the separation agreement between the former executive and us, issuance of those shares was subject to certain conditions that we have determined have not been, and are unlikely to be, met. Accordingly, the previously recorded expense of \$4,683 was reversed against equity-based compensation during the first quarter of 2010, which is included in Selling, general and administrative expense for the three months ended March 31, 2010.

A summary of our restricted stock, restricted stock unit (“RSU”) and stock option activity for the three months ended March 31, 2011 is presented in the table below.

|  | <b>Restricted<br/>Stock and<br/>RSU</b> | <b>Weighted<br/>Average<br/>Grant-Date<br/>Fair Value</b> | <b>Options</b> | <b>Weighted<br/>Average<br/>Exercise Price</b> |
|--|---|---|----------------|--|
| Outstanding as of January 1, 2011                | 718,009                                 | \$ 28.69  | 1,008,757      | \$ 30.02                                       |
| Granted  | 118,131                                 | 39.68   | -              | -  |
| Exercised  | -                                       | -   | (46,356)       | 22.62  |
| Vested   | (75,386)                                | 32.25   | -              | -  |
| Forfeited and expired                            | (16,019)                                | 30.51   | (48,437)       | 56.39  |
| Outstanding at March 31, 2011                    | <u>744,735</u>                          | 30.04   | <u>913,964</u> | 28.99  |
| Exercisable at March 31, 2011                    |   |   | <u>721,880</u> | 28.86  |
| Vested and expected to vest as of March 31, 2011 |   |   | <u>855,346</u> | 28.94  |

As of March 31, 2011, there was \$22,920 of unrecognized compensation cost related to non-vested equity-based compensation arrangements that is expected to be recognized over a weighted-average period of 1.5 years.

#### ***Performance Stock Units***

The Compensation Committee awards performance stock unit awards (“PSUs”) under our long-term incentive program (“LTI Program”). PSUs are scheduled to cliff-vest three years from the grant date and are subject to adjustment in the target range of 0% to 150%, based on the achievement of certain financial and quality-based performance goals set by the Compensation Committee over the performance period and conditioned on the employee’s continued service through the vest date. The actual number of PSUs that vest will be determined by the Compensation Committee at its sole discretion. As a result of the subjective nature of the PSUs, we have determined that, for accounting purposes, a mutual understanding of the key terms and conditions does not exist; and accordingly, these awards do not have an accounting grant date. The PSUs ultimately expected to vest will be recognized as expense over the requisite service period based on the estimated progress made towards the achievement of the pre-determined performance measures, as well as subsequent changes in the market price of our common stock since the awards do not have an accounting grant date. The compensation expense related to our PSUs granted assume that targets will be met and was \$755 for the three months ended March 31, 2011. As of March 31, 2011, there was \$9,351 of unrecognized compensation cost related to non-vested PSUs that is expected to be recognized over a weighted-average period of 2.6 years.

A summary of our PSU activity for the three months ended March 31, 2011 is presented in the table below.

|                                   | <b>PSUs</b>    | <b>Weighted<br/>Average<br/>Grant-Date<br/>Fair Value</b> |
|-----------------------------------|----------------|---|
| Outstanding as of January 1, 2011 | 144,801        | \$ 29.58  |
| Granted                           | 203,309        | 39.75   |
| Exercised                         | -              | -   |
| Vested                            | -              | -   |
| Forfeited and expired             | (5,604)        | 30.97   |
| Outstanding at March 31, 2011     | <u>342,506</u> | 35.59   |

#### **4. FAIR VALUE MEASUREMENTS**

Fair value measurements apply to all financial assets and financial liabilities that are being measured and reported on a fair value basis. Accounting standards require that fair value measurements be classified and disclosed in one of the following three categories: Level 1, defined as observable inputs such as quoted prices in active markets; Level 2, defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.



Our Condensed Consolidated Balance Sheets include the following financial instruments: cash and cash equivalents, receivables, investments, accounts payable and amounts accrued related to the investigation resolution discussed in Note 6 of these Condensed Consolidated Financial Statements. The carrying amounts of current assets and liabilities approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization.

Our Long-term investments include \$46,150 of municipal note investments with an auction reset feature (“auction rate securities”), at par value, as of both March 31, 2011 and December 31, 2010. Liquidity for these auction rate securities is typically provided by an auction process which allows holders to sell their notes and resets the applicable interest rate at pre-determined intervals, usually every seven, 14, 28 or 35 days. Auctions for these auction rate securities continued to fail during the three months ended March 31, 2011. An auction failure means that the parties wishing to sell their securities could not be matched with an adequate volume of buyers. As a result, our ability to liquidate and fully recover the carrying value of our remaining auction rate securities in the near term may be limited or non-existent. However, when there is a failed auction, the indenture governing the security requires the issuer to pay interest at a contractually defined rate that is generally above market rates for other types of similar instruments. We continue to receive interest payments on the auction rate securities we hold. Based on our analysis of anticipated cash flows, we have determined that it is more likely than not that we will be able to hold these securities until maturity or until market stability is restored. Additionally, there are government guarantees or municipal bond insurance in place and we have the ability and the present intent to hold these securities until maturity or market stability is restored. Accordingly, we do not believe our auction rate securities are impaired and as a result, we have not recorded any impairment losses for our auction rate securities. However, as these securities are believed to be in an inactive market, we have estimated the fair value of these securities using a discounted cash flow model and update these estimates on a quarterly basis. Our analysis considered, among other things, the collateralization underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows and the capital adequacy and expected cash flows of the subsidiaries that hold the securities. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties.

Our assets measured at fair value on a recurring basis subject to the disclosure requirements of fair value accounting guidance were as follows:

| Description  | Fair Value Measurements at March 31, 2011: |   |   |  |
|--|--|---|---|--|
|  | March 31,<br>2011                          | Quoted Prices<br>in<br>Active Markets<br>for Identical<br>Assets<br>(Level 1) | Significant<br>Other<br>Observable<br>Inputs<br>(Level 2) | Significant<br>Unobservable<br>Inputs<br>(Level 3) |
| Investments:   |  |   |   |  |
| Available-for-sale securities                          |  |   |   |  |
| Municipal variable rate bonds                          | \$ 89,870                                  | \$ 89,870   | \$ -  | \$ -   |
| Variable rate bond fund                                | 50,000                                     | 50,000  | -   | -  |
| Auction rate securities                                | 42,703                                     | -   | -   | 42,703   |
| Money market funds                                     | 41,720                                     | 41,720  | -   | -  |
| Corporate debt and other securities                    | 37,227                                     | 37,227  | -   | -  |
| Certificates of deposit                                | 21,128                                     | 21,128  | -   | -  |
| U.S. Government securities                             | 2,963                                      | 2,963   | -   | -  |
| Total investments                                      | \$ 285,611                                 | \$ 242,908  | \$ -  | \$ 42,703  |
| Restricted investments:                                |  |   |   |  |
| Available-for-sale securities                          |  |   |   |  |
| Money market funds                                     | \$ 54,677                                  | \$ 54,677   | \$ -  | \$ -   |
| Cash and cash equivalents                              | 27,577                                     | 27,577  | -   | -  |
| U.S. Government securities                             | 22,504                                     | 22,504  | -   | -  |
| Certificates of deposit                                | 1,054                                      | 1,054   | -   | -  |
| Total restricted investments                           | \$ 105,812                                 | \$ 105,812  | \$ -  | \$ -   |
| Amounts accrued related to investigation resolution(1) | \$ 287,073                                 | \$ -  | \$ 287,073  | \$ -   |

| Description  | Fair Value Measurements at December 31, 2010: |  |   |   |
|--|---|--|---|---|
|  | December 31, 2010                             | Quoted Prices in Active Markets for Identical Assets (Level 1) | Significant Other Observable Inputs (Level 2) | Significant Unobservable Inputs (Level 3) |
| <b>Investments:</b>                                    |   |  |   |   |
| Available-for-sale securities                          |   |  |   |   |
| Certificates of deposit                                | \$ 52,309                                     | \$ 52,309  | \$ -  | \$ -                                      |
| Auction rate securities                                | 42,245  | -  | -   | 42,245                                    |
| Municipal variable rate bonds                          | 29,120  | 29,120   | -   | -   |
| Corporate debt and other securities                    | 23,100  | 23,100   | -   | -   |
| Variable rate bond fund                                | 24,945  | 24,945   | -   | -   |
| Total investments                                      | \$ 171,719                                    | \$ 129,474   | \$ -  | \$ 42,245                                 |
| <b>Restricted investments:</b>                         |   |  |   |   |
| Available-for-sale securities                          |   |  |   |   |
| Money market funds                                     | \$ 54,908                                     | \$ 54,908  | \$ -  | \$ -                                      |
| Cash and cash equivalents                              | 27,581  | 27,581   | -   | -   |
| U.S. Government securities                             | 24,027  | 24,027   | -   | -   |
| Certificates of deposit                                | 1,053   | 1,053  | -   | -   |
| Total restricted investments                           | \$ 107,569                                    | \$ 107,569   | \$ -  | \$ -                                      |
| Amounts accrued related to investigation resolution(1) | \$ 337,542                                    | \$ -   | \$ 337,542                                    | \$ -                                      |

(1) These amounts are included in the short- and long-term portions of amounts accrued related to investigation resolution line items in our Condensed Consolidated Balance Sheets as of March 31, 2011 and December 31, 2010, respectively.

The following tables present our auction rate securities measured at fair value on a recurring basis using significant unobservable inputs (i.e., Level 3 data) as of March 31, 2011 and 2010, respectively.

|  | Fair Value Measurements Using Significant Unobservable Inputs (Level 3) |           |
|--|---|-----------|
|  | 2011  | 2010      |
| Beginning balance at January 1                                 | \$ 42,245   | \$ 51,710 |
| Realized gains (losses) in earnings (or changes in net assets) | -   | -         |
| Unrealized gains (losses) in other comprehensive income(a)     | 458   | 230       |
| Purchases, sales and redemptions(b)                            | -   | (6,300)   |
| Transfers in and/or out of Level 3                             | -   | -         |
| Ending balance at March 31                                     | \$ 42,703   | \$ 45,640 |

(a) As a result of the increase in the fair value of our investments in auction rate securities, we recorded a net unrealized gain of \$458 and \$230 to Accumulated other comprehensive loss during the three months ended March 31, 2011 and 2010, respectively. The increase in unrealized gain was driven by the continued stabilization and improvement within the municipal bond market.

(b) A \$6,300 auction rate security tranche was redeemed by the issuer at par in March 2010. Accordingly, we recorded an adjustment to the fair market valuation of the issuer's auction rate securities during the first quarter of 2010.

## 5. INCOME TAXES

As discussed in Note 6, we made a \$52,500 payment in March 2011 that was required in connection with an agreement to resolve certain class action complaints. Settlement payments are generally deductible when paid; therefore the payment had the effect of increasing Income taxes receivable and decreasing the current portion of Deferred income tax assets as of March 31, 2011. There was no impact to the effective income tax rate since the settlement was included in the determination of taxable income in prior periods. There has been no material change in the estimated non-deductible amounts associated with amounts accrued for investigation resolution during the three month period ended March 31, 2011.

Our effective income tax rate was 39.1% for the three months ended March 31, 2011 compared to 41.0% for the same three month period in the prior year. The decrease in the effective tax rate was primarily due to the lower non-deductible executive compensation costs in 2011 and higher Income before income taxes. The effective tax rate for the three months ended March 31, 2011 and 2010 was higher when compared to the statutory rate and was primarily attributable to certain non-deductible executive compensation costs.

## 6. COMMITMENTS AND CONTINGENCIES

### Government Investigations

#### *Deferred Prosecution Agreement*

As previously disclosed, in May 2009, we entered into a Deferred Prosecution Agreement (the "DPA") with the United States Attorney's Office for the Middle District of Florida (the "USAO") and the Florida Attorney General's Office, resolving previously disclosed investigations by those offices.

Under the one-count criminal information (the "Information") filed with the United States District Court for the Middle District of Florida (the "Federal Court") by the USAO pursuant to the DPA, we were charged with one count of conspiracy to commit health care fraud against the Florida Medicaid Program in connection with reporting of expenditures under certain community behavioral health contracts, and against the Florida Healthy Kids programs, under certain contracts, in violation of 18 U.S.C. Section 1349. The USAO recommended to the Federal Court that the prosecution be deferred for the duration of the DPA. Within five days of the expiration of the DPA the USAO will seek dismissal with prejudice of the Information, provided we have complied with the DPA.

The term of the DPA is thirty-six months, but such term may be reduced by the USAO to twenty-four months upon consideration of certain factors set forth in the DPA, including our continued remedial actions and compliance with all federal and state health care laws and regulations.

In accordance with the DPA, the USAO has filed, with the Federal Court, a statement of facts relating to this matter. As a part of the DPA, we retained an independent monitor (the "Monitor") for a period of 18 months from August 19, 2009 to February 18, 2011. The Monitor was selected by the USAO after consultation with us and was retained at our expense. In addition, we agreed to continue undertaking remedial measures to ensure full compliance with all federal and state health care laws. Among other things, the Monitor reviewed and evaluated our compliance with the DPA and all applicable federal and state health care laws, regulations and programs. The Monitor also reviewed, evaluated and, as necessary, made written recommendations concerning certain of our policies and procedures.

The DPA does not, nor should it be construed to, operate as a settlement or release of any civil or administrative claims for monetary, injunctive or other relief against us, whether under federal, state or local statutes, regulations or common law. Furthermore, the DPA does not operate, nor should it be construed, as a concession that we are entitled to any limitation of our potential federal, state or local civil or administrative liability. Pursuant to the terms of the DPA, we have paid the USAO a total of \$80,000.

#### *Civil Division of the United States Department of Justice*

In October 2008, the Civil Division of the United States Department of Justice (the "Civil Division") informed us that as part of its pending civil inquiry, it was investigating four *qui tam* complaints filed by relators against us under the whistleblower provisions of the False Claims Act, 31 U.S.C. sections 3729-3733. The seal in those cases was partially lifted for the purpose of authorizing the Civil Division to disclose to us the existence of the *qui tam* complaints. In May 2010, as part of the ongoing resolution discussions with the Civil Division, we were provided with a copy of the *qui tam* complaints, in response to our request, which otherwise remained under seal as required by 31 U.S.C. section 3730(b)(3).

As previously disclosed, we also learned from a docket search that a former employee filed a *qui tam* action on October 25, 2007 in state court for Leon County, Florida against several defendants, including us and one of our subsidiaries (the "Leon County *qui tam* suit"). As part of our discussions to resolve pending *qui tam* and related civil investigations discussed above, we were informed that the Leon County *qui tam* suit was filed by one of the federal *qui tam* relators and contains allegations similar to those alleged in one of the recently unsealed *qui tam* complaints.

On June 24, 2010, (i) the United States government filed its Notice of Election to Intervene in three of the *qui tam* matters, and (ii) we announced that we reached a preliminary agreement with the Civil Division, the Civil Division of the USAO, and the Civil Division of the United States Attorney's Office for the District of Connecticut to settle their pending inquiries. On June 25, 2010, the Federal Court lifted the seal in the three *qui tam* complaints in which the government had intervened (the "Florida Federal *qui tam* Actions"). Those complaints are now publicly available.

On April 26, 2011, we entered into certain settlement agreements, described below, which will resolve the pending inquiries of the Civil Division, the USAO and the United States Attorney's Office for the District of Connecticut (the "USAO Connecticut"). These settlement agreements are related to the Florida Federal *qui tam* Actions as well as another federal *qui tam* action that had been filed in the District of Connecticut (the "Connecticut Federal *qui tam* Action") and the Leon County *qui tam* Action. In connection with the execution of these settlement agreements, the Connecticut Federal *qui tam* Action and the Leon County *qui tam* Action were recently unsealed on April 29, 2011, and April 28, 2011, respectively.

The settlement agreements are with (a) the United States, with signatories from the Civil Division, the Office of Inspector General of the Department of Health and Human Services ("OIG-HHS") and the Civil Divisions of the USAO and the USAO Connecticut (the "Federal Settlement Agreement") and (b) the following states (collectively, the "Settling States"): Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Missouri, New York and Ohio (collectively, the "State Settlement Agreements"). The material terms of the Federal Settlement Agreement and the State Settlement Agreements are, collectively, substantively the same as the terms of the previously disclosed preliminary settlement with the Civil Division, the USAO and the USAO Connecticut. We have agreed, among other things, to pay the Civil Division a total of \$137,500 (the "Settlement Amount"), which is to be paid in installments over a period of up to 36 months after the date of the Federal Settlement Agreement (the "Payment Period") plus interest at the rate of 3.125% per year. The settlement includes an acceleration clause that would require immediate payment of the remaining balance of the Settlement Amount in the event that the Company is acquired or otherwise experiences a change in control during the Payment Period. In addition, the settlement provides for a contingent payment of an additional \$35,000 in the event that the Company is acquired or otherwise experiences a change in control within three years of the execution of the Federal Settlement Agreement and provided that the change in control transaction exceeds certain minimum transaction value thresholds as specified in the Federal Settlement Agreement.

In exchange for the payment of the Settlement Amount, the United States and the Settling States agree to release us from any civil or administrative monetary claim under the False Claims Act and certain other legal theories for certain conduct that was at issue in their inquiries and the *qui tam* complaints. Likewise, in consideration of the obligations in the Federal Settlement Agreement and the Corporate Integrity Agreement (as described below under *United States Department of Health and Human Services*), OIG-HHS agrees to release and refrain from instituting, directing or maintaining any administrative action seeking to exclude us from Medicare, Medicaid and other federal health care programs.

The Federal Settlement Agreement has not been executed by one of the relators. Under its terms, this failure to timely execute is deemed to be an objection to the Federal Settlement Agreement. In the case of an objection, the Federal Court is required to conduct a hearing (a "Fairness Hearing") to determine whether the proposed settlement is fair, adequate and reasonable under all the circumstances. The Federal Settlement Agreement and the State Settlement Agreements will not be effective until the earlier of (a) the execution of the Federal Settlement Agreement by the objecting relator or (b) entry by the Federal Court of a final order determining that the settlement is fair, adequate and reasonable under all the circumstances.

We can make no assurances that the objecting relator will execute the Federal Settlement Agreement or that the Federal Court will approve the settlement at a Fairness Hearing and the actual outcome of these matters may differ materially from the terms of the settlement.

We have discounted the total liability of \$137,500 for the resolution of these matters and accrued this amount at its estimated fair value, which amounted to approximately \$136,259 at March 31, 2011. In addition to the Settlement Amount, another \$5,000 for estimated *qui tam* relators attorneys' fees to be paid was accrued in 2010. Approximately \$31,848 and \$104,411 has been included in the current and long-term portions, respectively, of Amounts accrued related to the investigation resolution in our Condensed Consolidated Balance Sheet as of March 31, 2011. There can be no assurance that the Federal Settlement Agreement and the State Settlement Agreements will become effective and the actual outcome of these matters may differ materially from the terms of these settlements as described above.

## ***United States Department of Health and Human Services***

On April 26, 2011, the Company entered into a Corporate Integrity Agreement (the “Corporate Integrity Agreement”) with OIG-HHS. The Corporate Integrity Agreement has a term of five years and concludes the previously disclosed matters relating to the Company under review by OIG-HHS.

The Corporate Integrity Agreement formalizes various aspects of the Company’s ethics and compliance program and contains other requirements designed to help ensure the Company’s ongoing compliance with federal health care program requirements. The terms of the Corporate Integrity Agreement include certain organizational structure requirements, internal monitoring requirements, compliance training, screening processes for new employees, reporting requirements to OIG-HHS, and the engagement of an independent review organization to review and prepare written reports regarding, among other things, the Company’s reporting practices and bid submissions to federal health care programs.

### **Class Action Complaints**

Putative class action complaints were filed in October 2007 and in November 2007. These putative class actions, entitled *Eastwood Enterprises, L.L.C. v. Farha, et al.* and *Hutton v. WellCare Health Plans, Inc. et al.*, respectively, were filed in Federal Court against us, Todd Farha, our former chairman and chief executive officer, and Paul Behrens, our former senior vice president and chief financial officer. Messrs. Farha and Behrens were also officers of various subsidiaries of ours. The Eastwood Enterprises complaint alleged that the defendants materially misstated our reported financial condition by, among other things, purportedly overstating revenue and understating expenses in amounts unspecified in the pleading in violation of the Securities Exchange Act of 1934, as amended (“Exchange Act”). The Hutton complaint alleged that various public statements supposedly issued by the defendants were materially misleading because they failed to disclose that we were purportedly operating our business in a potentially illegal and improper manner in violation of applicable federal guidelines and regulations. The complaint asserted claims under the Exchange Act. Both complaints sought, among other things, certification as a class action and damages. The two actions were consolidated, and various parties and law firms filed motions seeking to be designated as Lead Plaintiff and Lead Counsel. In an Order issued in March 2008, the Federal Court appointed a group of five public pension funds from New Mexico, Louisiana and Chicago (the “Public Pension Fund Group”) as Lead Plaintiffs. In October 2008, an amended consolidated complaint was filed in this class action asserting claims against us, Messrs. Farha and Behrens, and adding Thaddeus Bereday, our former senior vice president and general counsel, as a defendant.

In January 2009, we and certain other defendants filed a joint motion to dismiss the amended consolidated complaint, arguing, among other things, that the complaint failed to allege a material misstatement by defendants with respect to our compliance with marketing and other health care regulations and failed to plead facts raising a strong inference of scienter with respect to all aspects of the purported fraud claim. The Federal Court denied the motion in September 2009 and we and the other defendants filed our answer to the amended consolidated complaint in November 2009. In April 2010, the Lead Plaintiffs filed their motion for class certification. On June 18, 2010, the USAO filed motions seeking to intervene and for a temporary stay of discovery of this matter. Discovery was stayed through March 17, 2011.

In August 2010, we reached agreement with the Lead Plaintiffs on the material terms of a settlement to resolve these matters. In December 2010, the terms of the settlement were documented in a formal settlement agreement (the “Stipulation Agreement”) that was subject to approval by the Federal Court following notice to all class members. On February 9, 2011, the Federal Court entered an order preliminarily approving the settlement and scheduled the final settlement hearing for May 4, 2011.

On May 4, 2011, the Federal Court entered an order (the “Approval Order”) approving the Stipulation Agreement. As required by the Stipulation Agreement, in March 2011 the Company paid \$52,500 into an escrow account for the benefit of the class. The Stipulation Agreement also provides, among other things, that the Company will make an additional cash payment to the class of \$35,000 by July 31, 2011 (the “July 2011 Payment”). It also requires, among other things, that the Company issue to the class tradable unsecured subordinated notes having an aggregate face value of \$112,500, with a fixed coupon of 6% and a maturity date of December 31, 2016. Additionally, the Company will be required to pay to the class an additional \$25,000 if the Company experiences a change in control at a share price of \$30 or more within three years of the date of the Stipulation Agreement.

With respect to the July 2011 Payment and as required by the Stipulation Agreement, by May 9, 2011, the Company is required to deliver to the escrow agent for the class a non-negotiable promissory note in the principal amount of \$35,000 (the "Note"). The Note is due and payable in full on July 31, 2011. The unpaid principal amount of the Note will accelerate and become immediately due and payable in the event of the Company's insolvency, a general assignment for the benefit of creditors, or the commencement by or against the Company of any action seeking reorganization, liquidation, dissolution, or similar treatment of the Company's debts under any law relating to bankruptcy, relief of debtors or similar laws. The unpaid principal will also accelerate in the event the Company or any third party seeks the appointment of a receiver or other similar official for the Company or its assets which, in the case of involuntary proceedings, has not been withdrawn or dismissed within 60 days after the filing of such proceeding. If the Company fails to pay the Note in full by July 31, 2011, then interest on the unpaid balance shall accrue at the rate and pursuant to the method set forth in 28 USC §1961 until all sums due are paid. In the event the payment is accelerated as described in the previous paragraph, then such interest will begin to accrue upon such acceleration.

As a result of this settlement having been reached, our estimate for the remaining resolution amount of this matter is \$147,500. We have discounted the \$147,500 liability for the resolution of this matter and accrued this amount at its estimated fair value, which amounted to approximately \$145,814 at March 31, 2011. Approximately \$31,951 and \$113,863 have been included in the current and long-term portions, respectively, of Amounts accrued related to investigation resolution in our Condensed Consolidated Balance Sheet as of March 31, 2011.

### **Derivative Lawsuits**

As previously disclosed, in connection with our government investigations, five putative stockholder derivative actions were filed between October and November 2007. Four of these actions were asserted against directors Kevin Hickey and Christian Michalik, our current directors who were directors prior to 2007, and against former directors Regina Herzlinger, Alif Hourani, Ruben King-Shaw and Neal Moszkowski, and former director and officer Todd Farha. These actions also named us as a nominal defendant. Two of these actions were filed in the Federal Court and two actions were filed in the Circuit Court for Hillsborough County, Florida (the "State Court"). The fifth action, filed in the Federal Court, asserts claims against directors Robert Graham, Kevin Hickey and Christian Michalik, our current directors who were directors at the time the action was filed, and against former directors Regina Herzlinger, Alif Hourani, Ruben King-Shaw and Neal Moszkowski, former director and officer Todd Farha, and former officers Paul Behrens and Thaddeus Bereday. A sixth derivative action was filed in January 2008 in the Federal Court and asserted claims against all of these defendants except Robert Graham. All six of these actions contended, among other things, that the defendants allegedly allowed or caused us to misrepresent our reported financial results, in amounts unspecified in the pleadings, and seek damages and equitable relief for, among other things, the defendants' supposed breach of fiduciary duty, waste and unjust enrichment. In April 2009, upon the recommendation of the Nominating and Corporate Governance Committee of the Board, the Board formed a Special Litigation Committee, comprised of a newly-appointed independent director, to investigate the facts and circumstances underlying the claims asserted in the derivative cases and to take such action with respect to these claims as the Special Litigation Committee determines to be in our best interests. In November 2009, the Special Litigation Committee filed a report with the Federal Court determining, among other things, that we should pursue an action against three of our former officers. In December 2009, the Special Litigation Committee filed a motion to dismiss the claims against the director defendants and to realign us as a plaintiff for purposes of pursuing claims against former officers Messrs. Farha, Behrens and Bereday.

In March 2010, a Stipulation of Partial Settlement ("Stipulation I") was filed in the Federal Court. Under the terms of Stipulation I, the plaintiffs in the federal action agreed that the Special Litigation Committee's motion to dismiss the director defendants and to realign us as a plaintiff should be granted in its entirety. The plaintiffs in the consolidated federal putative stockholder derivative action also agreed to dismiss their claims against Messrs. Farha, Behrens and Bereday. In turn, we paid to plaintiffs' counsel in the federal action attorneys' fees in the amount of \$1,688. In April 2010, the Federal Court entered an order preliminarily approving Stipulation I and directing us to provide notice to our stockholders. The Federal Court also approved Stipulation I and granted our motion to dismiss the director defendants and realigned us as the plaintiff in this action in July 2010. The case is now styled *WellCare v. Farha, et al.* In August 2010, Messrs. Farha, Behrens and Bereday filed a notice of appeal in the United States Court of Appeals for the Eleventh Circuit (the "Court of Appeals"), which is pending. In April 2011, the Federal Court stayed this action pending the conclusion of parallel federal criminal proceedings against Messrs. Farha, Behrens and Bereday.

In April 2010, a second Stipulation of Partial Settlement ("Stipulation II") was filed in the State Court. Under the terms of Stipulation II, the plaintiffs in the state action agreed that the Special Litigation Committee's motion to dismiss the director defendants and to realign us as a plaintiff should be granted in its entirety. In turn, we paid to plaintiffs' counsel in the state action attorneys' fees in the amount of \$563. The State Court approved Stipulation II and granted our motion to dismiss the director defendants and realigned us as the plaintiff in this action in June 2010. In July 2010, Mr. Farha filed a notice of appeal in this matter, which remains pending. In April 2011, the State Court stayed this action pending the conclusion of parallel federal criminal proceedings against Messrs. Farha, Behrens and Bereday.

In October 2010, we filed a motion for leave to file an amended complaint against Mr. Farha in the State Court action and a new lawsuit in Federal Court against Messrs. Behrens and Bereday, stating claims for breach of contract and breach of their fiduciary duties.

### ***Risk Adjustment Data Validation Audits***

CMS has performed and continues to perform Risk Adjustment Data Validation (“RADV”) audits of selected MA plans to validate the provider coding practices under the risk adjustment model used to calculate the premium paid for each MA member. Our Florida MA plan was selected by CMS for audit for the 2007 contract year and we anticipate that CMS will conduct additional audits of other plans and contract years on an ongoing basis. The CMS audit process selects a sample of 201 enrollees for medical record review from each contract selected. We have responded to CMS’s audit requests by retrieving and submitting all available medical records and provider attestations to substantiate CMS-sampled diagnosis codes. CMS will use this documentation to calculate a payment error rate for our Florida MA plan 2007 premiums. CMS has not indicated a schedule for processing or otherwise responding to our submissions.

CMS has indicated that payment adjustments resulting from its RADV audits will not be limited to risk scores for the specific beneficiaries for which errors are found, but will be extrapolated to the relevant plan population. In late December 2010, CMS issued a draft audit sampling and payment error calculation methodology that it proposes to use in conducting these audits. CMS invited public comment on the proposed audit methodology and announced in early February 2011 that it will revise its proposed approach based on the comments received. CMS has not given a specific timetable for issuing a final version of the audit sampling and payment error calculation methodology. Given that the RADV audit methodology is new and is subject to modification, there is substantial uncertainty as to how it will be applied to MA organizations like our Florida MA plan. At this time, we do not know whether CMS will require retroactive or subsequent payment adjustments to be made using an audit methodology that may not compare the coding of our providers to the coding of Original Medicare and other MA plan providers, or whether any of our other plans will be randomly selected or targeted for a similar audit by CMS. We are also unable to determine whether any conclusions that CMS may make, based on the audit of our plan and others, will cause us to change our revenue estimation process. Because of this lack of clarity from CMS, we are unable to estimate with any reasonable confidence a coding or payment error rate or predict the impact of extrapolating an applicable error rate to our Florida MA plan 2007 premiums and as a result, have not accrued a liability for the potential outcome. However, it is likely that a payment adjustment will occur as a result of these audits, and that any such adjustment could have a material adverse effect on our results of operations, financial position, and cash flows, possibly in 2011 and beyond.

### **Other Lawsuits and Claims**

Separate and apart from the legal matters described above, we are also involved in other legal actions that are in the normal course of our business, including, without limitation, provider disputes regarding payment of claims and disputes relating to the performance of contractual obligations with state agencies, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We currently believe that none of these actions, when finally concluded and determined, will have a material adverse effect on our financial position, results of operations or cash flows.

## **Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations.**

### **Forward Looking Statements**

This Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2011 ("2011 Form 10-Q") may include "forward-looking statements" within the meaning of Section 21E of the Securities Act of 1934, as amended, including, in particular, estimates, projections, guidance or outlook. Generally the words "believe," "expect," "anticipate," "may," "intend," "estimate," "anticipate," "plan," "project," "should" and similar expressions identify forward-looking statements, which generally are not historical in nature. These statements may contain information about financial prospects, economic conditions and trends that involve risks and uncertainties. Please refer to Risk Factors in Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2010 ("2010 Form 10-K") and in Part II, Item 1A of this 2011 Form 10-Q, for a discussion of certain risk factors which could materially affect our business, financial condition, cash flows, or results of operations. If any of those risks, or other risks not presently known to us or that we currently believe to not be significant, do materialize or develop into actual events, our business, financial condition, results of operations or prospects could be materially adversely affected. Given these risks and uncertainties, we can give no assurances that any results or events projected or contemplated by our forward-looking statements will in fact occur and we caution you not to place undue reliance on these statements. We caution you that we do not undertake any obligation to update forward-looking statements made by us.

### **Overview**

#### *Executive Summary*

We provide managed care services exclusively to government-sponsored health care programs, serving approximately 2.4 million members nationwide in our Medicaid and Medicare business lines. We believe that our broad range of experience and exclusive government focus allows us to efficiently and effectively serve our members and providers, while managing our ongoing operations. Our strategic priorities for 2011 include improving health care quality and access for our members, ensuring a competitive cost position and delivering prudent and profitable growth. We continue to work closely with providers and government clients to further enhance health care delivery and improve the quality of, and enhance access to, government health care services for our members. Our cost management initiatives are concentrated on aligning our expense structure with our current revenue base through process improvement and other initiatives; focusing on ensuring a competitive cost position in terms of both administrative and medical expenses. We are also focused on programs that help governments provide quality care within their fiscal constraints and present us with long-term opportunities for prudent and profitable growth.

#### *General Economic and Political Environment*

New governors are in office in nearly all of our current Medicaid markets. These new administrations have been considering changes to current Medicaid programs in their respective states. These changes may include moving programs into managed care, such as the aged, blind and disabled ("ABD") populations; expanding existing programs to provide coverage to those who are currently uninsured; and reprocurement of existing managed care programs. State budget shortfalls in many states will be a significant consideration in any changes to existing Medicaid programs.

#### *Premium Rates and Payments*

The states in which we operate continue to experience fiscal challenges which have led to budget cuts and reductions in Medicaid premiums in certain states or rate increases that are below medical cost trends. In particular, we continue to experience pressure on rates in Florida and Georgia, two states from which we derive a substantial portion of our revenue.

#### *Health Care Reform*

In March 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "2010 Acts") became law. The health reforms in the 2010 Acts present both challenges and opportunities for our Medicaid business. We anticipate that the reforms could significantly increase the number of citizens who are eligible to enroll in our Medicaid products. However, state budgets continue to be strained due to economic conditions and uncertain levels of federal financing for current populations. As a result, the effects of any potential future expansions are uncertain, making it difficult to determine whether the net impact of the 2010 Acts will be positive or negative for our Medicaid business.

## ***Business and Financial Outlook***

### *Business Trends*

We received rate increases in most of our Medicaid markets during the third quarter of 2010. We received rate increases of approximately 2.5% to 3.0% in Florida effective September 1, 2010 and 1.5% to 2.0% in Georgia effective July 1, 2010. Hawaii program rate increases, which we believe have improved the stability of the program, also were effective July 1, 2010. New York program rate increases were also implemented during the third quarter of 2010 that were effective April 1, 2010.

In February, the Georgia Department of Community Health (“Georgia DCH”) notified us that it intends to amend our current Georgia Medicaid contract to extend it by one year to June 30, 2013. The amendment is also expected to include a renewal option allowing the contract term to be further extended, at the option of Georgia DCH, by one additional year to June 30, 2014.

Louisiana and Texas, states in which we have offered Medicare Advantage (“MA”) plans for several years, as well as Kentucky, have announced plans to expand Medicaid managed care programs that would be very complementary to our existing operations and infrastructure. Florida and Hawaii are also considering expansions of their Medicaid managed care programs.

As part of the 2010 Acts, MA payment benchmarks for 2011 were frozen at 2010 levels. This places increased importance on administrative cost improvements and effective medical cost initiatives.

Based on the outcome of our 2011 stand-alone prescription drug plan (“PDP”) bids, which resulted in our plans being below the benchmarks in 20 of the 34 Centers for Medicare & Medicaid Services (“CMS”) regions, up from 19 regions in 2010, we were eligible for auto-assignment of low income subsidy beneficiaries in those 20 regions for January 2011 enrollment. In addition, we maintained our auto-assigned members in eight other CMS regions where we bid within a de minimis range of the benchmark.

Some hospital contracts are directly tied to state Medicaid fee schedules, in which case reimbursement levels may be adjusted up or down, generally on a prospective basis, based on adjustments made by the state to the fee schedule. We have experienced, and may continue to experience, such adjustments. Unless such adjustments are mitigated by an increase in premiums, our profitability will be negatively impacted.

We anticipate that our withdrawal from the private fee-for-service (“PFFS”) product effective December 31, 2009 may provide approximately \$40.0 million to \$60.0 million of excess capital in the insurance companies that underwrote this line of business, which we may be able to distribute to our unregulated subsidiaries through dividends or the repayment of surplus notes. However, we currently believe we will not have the benefit of these distributions until late 2011 or possibly later, if at all. Any dividend or return of surplus capital of our applicable insurance subsidiaries, including the timing and amount of any dividend, would be subject to a variety of factors, which could materially change the aforementioned timing and amount. Those factors principally include the financial performance of other lines of business that operate in those insurance subsidiaries, approval from regulatory agencies and potential changes in regulatory capital requirements.

### *Strategic and Organizational Restructuring*

In August 2010, we announced a strategic and organizational restructuring with the objective of ensuring administrative efficiency and a competitive cost structure. The restructuring included a workforce reduction and the elimination of a significant number of open positions resulting from streamlining and improving business processes and operations, including the centralization and consolidation of certain functions. We also allocated new resources and directed substantial investments to priority areas such as health care quality, compliance, information technology, and business development.

Assessment of opportunities to improve the efficiency and effectiveness of our administrative processes remains an important discipline for us. We continue to evaluate our operations in order to achieve our long-term target of an administrative expense ratio in the low 10% range. In addition, as part of our medical cost initiatives, we have implemented provider contracting, case and disease management and pharmacy initiatives. These medical cost initiatives contributed to the year-over-year reductions we achieved for our medical benefits ratios.

## *Financial Impact of Government Investigations and Litigation*

For further discussion of government investigations and litigation including the associated financial impact, please refer to our *Selling, general and administrative expense* discussion under *Results of Operations* below and Part I – Note 6 – *Commitments and Contingencies*.

### **Basis of Presentation**

#### *Segments*

Reportable operating segments are defined as components of an enterprise for which discrete financial information is available and evaluated on a regular basis by the chief operating decision-maker to determine how resources should be allocated to an individual segment and to assess performance of those segments. We have three reportable operating segments within our two main business lines: Medicaid, MA and PDP. The residual financial impact from the PFFS product that we exited effective December 31, 2009 is reported within the MA segment.

#### *Medicaid*

Medicaid was established to provide medical assistance to low-income and disabled persons. It is state operated and implemented, although it is funded and regulated by both the state and federal governments. Our Medicaid plans include plans for beneficiaries of Temporary Assistance for Needy Families (“TANF”) programs, Supplemental Security Income (“SSI”) programs, Aged Blind and Disabled (“ABD”) programs and state-based programs that are not part of the Medicaid program, such as Children’s Health Insurance Programs (“CHIP”) and Family Health Plus (“FHP”) programs for qualifying families that are not eligible for Medicaid because they exceed the applicable income thresholds. TANF generally provides assistance to low-income families with children; ABD and SSI generally provide assistance to low-income aged, blind or disabled individuals.

The Medicaid programs and services we offer to our members vary by state and county and are designed to serve our various constituencies effectively in the communities we serve. Although our Medicaid contracts determine to a large extent the type and scope of health care services that we arrange for our members, in certain markets we customize our benefits in ways that we believe make our products more attractive. Our Medicaid plans provide our members with access to a broad spectrum of medical benefits from many facets of primary care and preventive programs to full hospitalization and tertiary care.

In general, members are required to use our network, except in cases of emergencies, transition of care or when network providers are unavailable to meet their medical needs, and generally must receive a referral from their primary care provider (“PCP”) in order to receive health care from specialists, such as surgeons or neurologists. Members do not pay any premiums, deductibles or co-payments for most of our Medicaid plans.

#### *MA*

Medicare is a federal program that provides eligible persons age 65 and over, and some disabled persons, a variety of hospital, medical and prescription drug benefits. Our MA segment consists of MA plans which, following the exit of our PFFS product on December 31, 2009, is comprised mainly of coordinated-care plans (“CCPs”). MA is Medicare’s managed care alternative original Medicare fee-for-service (“Original Medicare”), which provides individuals standard Medicare benefits directly through CMS. CCPs are administered through health maintenance organizations (“HMOs”) and generally require members to seek health care services and select a PCP from a network of health care providers. In addition, we offer Medicare Part D coverage, which provides prescription drug benefits, as a component of our MA plans.

We cover a wide spectrum of medical services through our MA plans, including in some cases, additional benefits not covered by Original Medicare, such as vision, dental and hearing services. Through these enhanced benefits, the out-of-pocket expenses incurred by our members are reduced, which allows our members to better manage their health care costs.

Most of our MA plans require members to pay a co-payment, which varies depending on the services and level of benefits provided. Typically, members of our MA CCPs are required to use our network of providers except in cases such as emergencies, transition of care or when specialty providers are unavailable to meet a member's medical needs. MA CCP members may see out-of-network specialists if they receive referrals from their PCPs and may pay incremental cost-sharing. In most of our markets, we also offer special needs plans to individuals who are dually eligible for Medicare and Medicaid. These plans, commonly called D-SNPs, are designed to provide specialized care and support for beneficiaries who are eligible for both Medicare and Medicaid. We believe that our D-SNPs are attractive to these beneficiaries due to the enhanced benefit offerings and clinical support programs.

#### *PDP*

We offer stand-alone Medicare Part D coverage to Medicare-eligible beneficiaries through our PDP segment. The Medicare Part D prescription drug benefit is supported by risk sharing with the federal government through risk corridors designed to limit the losses and gains of the drug plans and by reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for risk factor payments. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries. The Medicare Part D program offers national in-network prescription drug coverage that is subject to limitations in certain circumstances.

Depending on medical coverage type, a beneficiary has various options for accessing drug coverage. Beneficiaries enrolled in Original Medicare can either join a stand-alone PDP or forego Part D drug coverage. Beneficiaries enrolled in MA CCPs can join a plan with Part D coverage, select a separate Part D plan, or forego Part D coverage.

#### ***Segment Financial Performance Measures***

We use three measures to assess the performance of our reportable operating segments: premium revenue, medical benefits ratio ("MBR") and gross margin. MBR measures the ratio of our medical benefits expense to premiums earned, after excluding Medicaid premium taxes. Gross margin is defined as premium revenue less medical benefits expense.

Our profitability depends in large part on our ability to, among other things, effectively price our health and prescription drug plans; predict and effectively manage medical benefits expense relative to the primarily fixed premiums we receive, including reserve estimates and pharmacy costs; contract with health care providers; and attract and retain members. In addition, factors such as regulation, competition and general economic conditions affect our operations and profitability. The effect of escalating health care costs, as well as any changes in our ability to negotiate competitive rates with our providers may impose further risks to our profitability and may have a material impact on our business, financial condition and results of operations.

#### *Premium Revenue*

We receive premiums from state and federal agencies for the members that are assigned to, or have selected, us to provide health care services under Medicaid and Medicare. The primarily fixed premiums we receive for each member vary according to the specific government program. The premiums we receive under each of our government benefit plans are generally determined at the beginning of the contract period. However, these premiums are subject to adjustment throughout the term of the contract. Our Medicare premiums and certain of our Medicaid premiums are subject to subsequent modification based on the health status of each member. A portion of our premiums for certain Medicaid programs is also subject to refund if our medical costs for those programs are less than a specified minimum percentage. For further information regarding premium revenues, please refer below to *Premium Revenue Recognition* under *Critical Accounting Estimates*.

#### *Medical Benefits Expense*

Our largest expense is the cost of medical benefits that we provide, which is based primarily on our arrangements with health care providers and utilization of health care services by our members. Our arrangements with providers primarily fall into two broad categories: capitation arrangements, pursuant to which we pay the capitated providers a fixed fee per member and in some instances, additional fees for certain services, as well as risk-sharing arrangements, pursuant to which the provider assumes a portion of the risk of the cost of the health care provided. Other components of medical benefits expense are variable and require estimation and ongoing cost management.

We use a variety of techniques to manage our medical benefits expense, including payment methods to providers, referral requirements, quality and disease management programs, reinsurance and member co-payments and premiums for some of our Medicare plans. National health care costs have been increasing at a higher rate than the general inflation rate and relatively small changes in our medical benefits expense relative to premiums that we receive can create significant changes in our financial results. Changes in health care laws, regulations and practices, levels of use of health care services, competitive pressures, hospital costs, major epidemics, terrorism or bio-terrorism, new medical technologies and other external factors could reduce our ability to manage our medical benefits expense effectively.

Estimation of medical benefits payable and medical benefits expense is our most significant critical accounting estimate. For further information regarding medical benefits expense, please refer below to *Estimating Medical Benefits Expense and Medical Benefits Payable* under *Critical Accounting Estimates*.

#### *Gross Margin and Medical Benefits Ratio*

Our primary tools for measuring profitability are gross margin and MBR. Changes in gross margin and MBR from period to period result from, among other things, changes in Medicaid and Medicare funding, changes in the mix of Medicaid and Medicare membership, our ability to manage medical costs and changes in accounting estimates related to incurred but not reported (“IBNR”) claims. We use gross margin and MBRs both to monitor our management of medical benefits and medical benefits expense and to make various business decisions, including what health care plans to offer, what geographic areas to enter or exit and which health care providers to select. Although gross margin and MBRs play an important role in our business strategy, we may be willing to enter new geographical markets and/or enter into provider arrangements that might produce a less favorable gross margin and MBR if those arrangements, such as capitation or risk sharing, would likely lower our exposure to variability in medical costs or for other reasons.

## Results of Operations

### For the Three Months Ended March 31, 2011 Compared to the Three Months Ended March 31, 2010

#### Summary of Financial Information

The following table sets forth condensed consolidated statements of income data, as well as other key data used in our results of operations discussion. These historical results are not necessarily indicative of results to be expected for any future period.

| Consolidated Statement of Operations Data: | For the Three Months Ended<br>March 31, |                |
|--|---|----------------|
|  | 2011                                    | 2010           |
|  | (In millions, except per share data)    |                |
| Revenues:                                  |   |                |
| Premium                                    | \$ 1,472.4                              | \$ 1,353.5     |
| Investment and other income                | 2.3                                     | 2.5            |
| Total revenues                             | <u>1,474.7</u>                          | <u>1,356.0</u> |
| Expenses:                                  |   |                |
| Medical benefits                           | 1,245.0                                 | 1,166.0        |
| Selling, general and administrative        | 169.2                                   | 163.6          |
| Medicaid premium taxes                     | 18.9                                    | 9.7            |
| Depreciation and amortization              | 6.5                                     | 5.8            |
| Interest                                   | 0.1                                     | 0.0            |
| Total expenses                             | <u>1,439.7</u>                          | <u>1,345.1</u> |
| Income before income taxes                 | 35.0                                    | 10.9           |
| Income tax expense                         | 13.7                                    | 4.5            |
| Net income                                 | <u>\$ 21.3</u>                          | <u>\$ 6.4</u>  |
| Net income per common share:               |   |                |
| Basic                                      | \$ 0.50                                 | \$ 0.15        |
| Diluted                                    | \$ 0.50                                 | \$ 0.15        |
| Consolidated MBR                           | 85.7%                                   | 86.8%          |

#### Membership

| Membership:      | March 31,<br>2011 | December 31,<br>2010 | March 31,<br>2010 |
|------------------|-------------------|----------------------|-------------------|
| Medicaid         | 1,329,000         | 1,340,000            | 1,332,000         |
| MA               | 119,000           | 116,000              | 118,000           |
| PDP              | 935,000           | 768,000              | 736,000           |
| Total Membership | <u>2,383,000</u>  | <u>2,224,000</u>     | <u>2,186,000</u>  |

As of March 31, 2011, we served approximately 2,383,000 members; an increase of 159,000 members from December 31, 2010 and 197,000 members from March 31, 2010. We experienced membership growth in both our MA and PDP segments. For our MA segment, we focused on our membership growth activities during the annual election period in 2010. Our products are designed to achieve an appropriate financial rate of return with benefit designs that are attractive to both current and prospective members. We invested in strengthening our sales processes and organization. In light of the shortened selling season and the elimination of the open enrollment period, we also invested to ensure an effective on-boarding experience for our new members. As of March 31, 2011 we added approximately 3,000 members from December 31, 2010. In our PDP segment, our plans are below the benchmark in 20 of the 34 CMS regions, which is an increase of one region from 2010. Additionally, we are within the de minimis range in an additional eight regions. As a result, we added approximately 167,000 members as of March 31, 2011 compared to December 31, 2010. These membership increases during the 2011 first quarter were partially offset by an overall decrease in Medicaid membership. We believe Medicaid membership growth opportunities exist in the states in which we currently operate, as well as states that we may decide to enter as a new market.

## Summary of Consolidated Financial Results

### Net income

For the three months ended March 31, 2011, our net income was \$21.3 million compared to \$6.4 million the same period in 2010. Excluding investigation-related and litigation-resolution costs of \$6.9 million and \$0.9 million, net of tax, for the three months ended March 31, 2011 and 2010, respectively, net income increased by \$20.9 million compared to the same period in the prior year. The increase resulted mainly from the impact of net favorable development of prior period medical benefits payable, which led to improved results in our Medicaid and Medicare segments, as well as, reductions in selling, general and administrative (“SG&A”) expense.

### Premium revenue

Premium revenue for the three months ended March 31, 2011 increased by approximately \$118.9 million, or 8.8%, to \$1,472.4 million from \$1,353.5 million for the same period in the prior year. The increase in premium revenue is primarily attributable to the impact of rate increases in our Medicaid markets which were effective during the third quarter of 2010 and membership growth during the first quarter of 2011 in our PDP segment. Premium revenue includes \$18.9 million and \$9.7 million of Medicaid premium taxes for the three months ended March 31, 2011 and 2010, respectively.

### Medical benefits expense

Total medical benefits expense for the three months ended March 31, 2011 increased \$79.0 million, or 6.8%, to \$1,245.0 million from \$1,166.0 million for the same period in 2010. The increase in medical benefits expense is due mainly to the membership growth in our PDP segment, partially offset by an increase in net favorable development of prior period medical benefits payable, which amounted to \$51.0 million for the three months ended March 31, 2011 compared to \$4.6 million for the same period in 2010.

The consolidated MBR, excluding the impact from our PFFS product, was 85.8% and 87.8% for the three months ended March 31, 2011 and 2010, respectively. The change in MBR was primarily due to the net prior period reserve development.

### Selling, general and administrative expense

SG&A expense includes aggregate costs related to the resolution of the previously disclosed governmental and Company investigations and litigation, such as: legal fees, fair value accretion of settlement accruals and other related costs. Refer to Part I – Note 6 – *Commitments and Contingencies* for a further discussion of investigation-related and litigation costs. We believe it is appropriate to evaluate SG&A expense exclusive of these investigation-related and litigation costs because we do not consider them to be indicative of our long-term business operations. A reconciliation of SG&A expense, including and excluding investigation-related costs, is presented below.

|  | <b>For the Three Months Ended</b> |                 |
|--|-----------------------------------|-----------------|
|  | <b>March 31,</b>                  |                 |
|  | <b>2011</b>                       | <b>2010</b>     |
|  | (In millions)                     |                 |
| SG&A expense   | \$ 169.2                          | \$ 163.6        |
| Adjustments:   |                                   |                 |
| Investigation-related and litigation resolution costs              | (2.0)                             | (0.4)           |
| Investigation-related administrative costs                         | (8.7)                             | (0.9)           |
| Investigation-related and litigation costs                         | (10.7)                            | (1.3)           |
| SG&A expense, excluding investigation-related and litigation costs | <u>\$ 158.5</u>                   | <u>\$ 162.3</u> |

Excluding the investigation-related and litigation costs, our SG&A expense for the three months ended March 31, 2011, decreased approximately \$3.8 million, or 2.3%, to \$158.5 million from \$162.3 million for the same period in prior year. The reduction in SG&A expense was driven by the change in the Medicare marketing calendar and the elimination of the open enrollment period, which reduced our Medicare marketing expense for the three months ended March 31, 2011 compared to the same period in the prior year. Improvements in operating efficiency also contributed to this expense reduction. Our SG&A expense as a percentage of total revenue, excluding premium taxes (“SG&A ratio”), was 11.6% for the three months ended March 31, 2011 compared to 12.2% for the same period in prior year. After excluding the investigation-related and litigation costs, our SG&A ratio for the three months ended March 31, 2011 was 10.9% compared to 12.1% for the same period in the prior year. Our SG&A ratio, excluding investigation-related and litigation costs, represents solid progress toward our long-term goal of an adjusted SG&A ratio in the low 10% range, based on our current business mix. Business simplification projects, process management in our shared services functions, and continued evaluation of our organizational design continue to drive improvement in our administrative cost structure.



*Medicaid premium taxes*

Medicaid premium taxes incurred for the three months ended March 31, 2011 and 2010 were \$18.9 million and \$9.7 million, respectively. The increase was mainly due to the reinstatement of premium taxes by the State of Georgia in July 2010. In October 2009, the State of Georgia stopped assessing taxes on Medicaid premiums remitted to us, which resulted in an equal reduction to premium revenues and expenses. However, effective July 1, 2010, the State of Georgia began assessing premium taxes again on Medicaid premiums. Therefore, during the first quarter of 2010, we were not assessed nor did we remit any taxes on premiums in Georgia. We were assessed and remitted taxes on premiums in Hawaii, Missouri, New York and Ohio both the 2011 and 2010 periods.

We exclude Medicaid premium taxes from premium revenue when calculating our key ratios as we believe the premium tax is not indicative of our operating performance.

*Income tax expense*

Income tax expense for the three months ended March 31, 2011 was \$13.7 million compared to \$4.5 million for the same period in the prior year. Our effective income tax rate was 39.1% for the three months ended March 31, 2011 compared to 41.0% for the same three month period in the prior year. The decrease in the effective tax rate in the 2011 period was primarily attributable to a decrease in certain non-deductible executive compensation costs in 2011 and from improvement in our income before income taxes. The effective tax rate was higher when compared to the statutory rate for the three months ended March 31, 2011 and 2010, and was also due to certain non-deductible executive compensation costs.

**Reconciling Segment Results**

The following table reconciles our reportable segment results to income before income taxes, as reported under GAAP.

| Reconciling Segment Results Data: | For the Three Months Ended March 31, |              |
|-----------------------------------|--------------------------------------|--------------|
|                                   | 2011                                 | 2010         |
| Gross margin:                     | (Dollars in millions)                |              |
| Medicaid                          | \$ 152.1                             | \$ 107.3     |
| MA                                | 77.7                                 | 74.9         |
| PDP                               | (2.4)                                | 5.3          |
| Total gross margin                | <u>227.4</u>                         | <u>187.5</u> |
| Investment and other income       | 2.3                                  | 2.5          |
| Other expenses                    | (194.7)                              | (179.1)      |
| Income before income taxes        | <u>35.0</u>                          | <u>10.9</u>  |

**Medicaid Segment Results**

| Medicaid Segment Results Data:         | For the Three Months Ended March 31, |                  |
|--|--------------------------------------|------------------|
|  | 2011                                 | 2010             |
| Premium revenue                        | \$ 836.9                             | \$ 799.4         |
| Medicaid premium taxes                 | 18.9                                 | 9.7              |
| Total premiums                         | 855.8                                | 809.1            |
| Medical benefits expense               | 703.7                                | 701.8            |
| Gross margin                           | <u>\$ 152.1</u>                      | <u>\$ 107.3</u>  |
| Medicaid Membership:                   |                                      |                  |
| Georgia                                | 559,000                              | 537,000          |
| Florida                                | 410,000                              | 422,000          |
| Other states                           | 360,000                              | 373,000          |
|  | <u>1,329,000</u>                     | <u>1,332,000</u> |
| Medicaid MBR (excluding premium taxes) | 84.1%                                | 87.8%            |

Excluding Medicaid premium taxes, Medicaid premium revenue for the three months ended March 31, 2011 increased \$37.5 million when compared to the same period in the prior year. The increase in premium revenue was mainly due to rate increases that were effective in most markets during the third quarter of 2010.

Medicaid medical benefits expense for the three months ended March 31, 2011 increased \$1.9 million when compared to the same period in prior year due mainly to a change in member mix, partially offset by the impact of net favorable development of prior period medical benefits payable and the impact of medical cost initiatives that we have implemented. Our Medicaid MBR for the three months ended March 31, 2011 was 84.1% compared to 87.8% for the same period in the prior year. The decrease in MBR was primarily due to the net favorable prior period development of medical benefits payable. We expect the full year MBR for our Medicaid segment to decrease in 2011 when compared to 2010, due to the favorable development of medical benefits payable that we recognized during the first quarter of 2011 and utilization modestly below historical levels, offset in part by our expectation that the state rate environment will be challenging.

### **MA Segment Results**

|                          | <b>For the Three Months Ended March 31,</b> |             |
|--------------------------|---|-------------|
|                          | <b>2011</b>                                 | <b>2010</b> |
| MA Segment Results Data: | (Dollars in millions)                       |             |
|                          | \$  | \$          |
| Premium revenue          | 354.7                                       | 351.1       |
| Medical benefits expense | 277.0                                       | 276.2       |
|                          | \$  | \$          |
| Gross margin             | 77.7  | 74.9        |
| MA Membership            | 119,000                                     | 118,000     |
| MA MBR                   | 78.1%                                       | 78.7%       |

MA premium revenue for the three months ended March 31, 2011 increased \$3.6 million when compared to the same period in the prior year. Membership increased by approximately 1,000 members to 119,000 as of March 31, 2011, from 118,000 as of March 31, 2010. The increase in MA premium revenue and membership was attributable to our product design, strengthening of our sales processes and heightened focus on membership growth activities during the annual election period in 2010. MA gross margin increased by \$2.8 million for the three months ended March 31, 2011, to \$77.7 million from \$74.9 million for the same period in prior year due to increased premiums. MA segment MBR decreased by 0.6% in 2011 compared to 2010 primarily due to the net favorable prior period development of medical benefits payable. We currently expect that the MA segment MBR in 2011 will increase relative to 2010 as the benefit we experienced in 2010 from the wind-down of our PFFS plans will not recur in 2011.

### **PDP Segment Results**

|                           | <b>For the Three Months Ended March 31,</b> |             |
|---------------------------|---|-------------|
|                           | <b>2011</b>                                 | <b>2010</b> |
| PDP Segment Results Data: | (Dollars in millions)                       |             |
|                           | \$  | \$          |
| Premium revenue           | 261.9                                       | 193.3       |
| Medical benefits expense  | 264.3                                       | 188.0       |
|                           | \$  | \$          |
| Gross margin              | (2.4)                                       | 5.3         |
| PDP Membership            | 935,000                                     | 736,000     |
| PDP MBR                   | 100.9%                                      | 97.2%       |

During the three months ended March 31, 2011 PDP premium revenue increased \$68.6 million when compared to the same period in the prior year. The increase in premium revenue during 2011 is primarily the result of higher membership largely due to our 2011 bids. Membership increased approximately 199,000 members from March 31, 2010 to March 31, 2011. PDP MBR for the three months ended March 31, 2011 increased 3.6% over the same period in 2010 due to our bid results, member mix and higher utilization.

## Liquidity and Capital Resources

### Overview

Each of our existing and anticipated sources of cash is impacted by operational and financial risks that influence the overall amount of cash generated and the capital available to us. For a further discussion of risks that can affect our liquidity, see Part I – Item 1A – *Risk Factors* included in our 2010 Form 10-K.

### Cash & Investment Positions

We currently believe that we will be able to meet our known monetary obligations, including the terms of the settlement agreements reached to resolve the government investigation and related litigation, and maintain sufficient liquidity to operate our business. However, one or more of our regulators could require one or more of our subsidiaries to maintain minimum levels of statutory net worth in excess of the amount required under the current applicable state laws if the regulators were to determine that such a requirement were in the interest of our members. Further, there may be other potential adverse developments that could impede our ability to meet our obligations. The table below presents our cash and investment positions as of March 31, 2011 and December 31, 2010.

|                            | March 31,<br>2011     | December 31,<br>2010 |
|----------------------------|-----------------------|----------------------|
| Cash and cash equivalents: | (Dollars in millions) |                      |
| Regulated                  | \$ 1,105.1            | \$ 1,168.9           |
| Unregulated                | 127.8                 | 190.6                |
|                            | <u>\$ 1,232.9</u>     | <u>\$ 1,359.5</u>    |
| Investments:               |                       |                      |
| Regulated                  |                       |                      |
| Auction rate securities    | \$ 40.4               | \$ 40.2              |
| Other                      | 242.8                 | 129.1                |
|                            | <u>\$ 283.2</u>       | <u>\$ 169.3</u>      |
| Unregulated                |                       |                      |
| Auction rate securities    | \$ 2.3                | \$ 2.3               |
| Other                      | 0.1                   | 0.1                  |
|                            | <u>2.4</u>            | <u>2.4</u>           |
|                            | <u>\$ 285.6</u>       | <u>\$ 171.7</u>      |

Regulated cash and cash equivalents can fluctuate significantly in a particular period depending on the timing of receipts for premiums from our government partners. Our unregulated cash and cash equivalents decreased during the three months ended March 31, 2011 primarily as a result of \$52.5 million paid in March 2011 in connection with the preliminary resolution of certain class action complaints as well as the payment of certain investigation-related and litigation resolution costs during the first quarter of 2011. Our regulated investments increased as a result of the investment of funds to higher yielding investment alternatives.

### Initiatives to Increase Our Unregulated Cash

We are pursuing alternatives to raise additional unregulated cash. Some of these initiatives include, but are not limited to, obtaining dividends from certain of our regulated subsidiaries, to the extent of the current dividend capacity for such subsidiaries based on the states' dividend restrictions, and consideration of accessing the debt or equity capital markets. However, we cannot provide any assurances that we will obtain applicable state regulatory approvals for paying additional dividends to our non-regulated subsidiaries from our regulated subsidiaries, or be successful in accessing the capital markets if we determine to do so.

### Credit Facility

We entered into a credit agreement on May 12, 2010, which was subsequently amended on May 25, 2010 and March 3, 2011 (as amended, the "Credit Agreement"). The Credit Agreement provides for a \$65.0 million committed revolving credit facility that expires on November 12, 2011. Borrowings under the Credit Agreement may be used for general corporate purposes.

The Credit Agreement is guaranteed by us and our subsidiaries, other than our HMO and insurance subsidiaries. In addition, the Credit Agreement is secured by first priority liens on our personal property and the personal property of our subsidiaries, other than the personal property and equity interests of our HMO and insurance subsidiaries.

Borrowings designated by us as Alternate Base Rate borrowings bear interest at a rate per annum equal to (i) the greatest of (a) the Prime Rate (as defined in the Credit Agreement) in effect on such day; (b) the Federal Funds Effective Rate (as defined in the Credit Agreement) in effect on such day plus 1/2 of 1%; and (c) the Adjusted LIBO Rate (as defined in the Credit Agreement) for a one month interest period on such day plus 1%; plus (ii) 1.5%. Borrowings designated by us as Eurodollar borrowings bear interest at a rate per annum equal to the Adjusted LIBO Rate for the interest period in effect for such borrowing plus 2.5%.

The Credit Agreement includes negative covenants that limit certain of our activities, including restrictions on our ability to incur additional indebtedness, and financial covenants that require a minimum ratio of cash flow to total debt, a maximum ratio of total liabilities to consolidated net worth and a minimum level of statutory net worth for our HMO and insurance subsidiaries.

The Credit Agreement also contains customary representations and warranties that must be accurate in order for us to borrow under the Credit Agreement. In addition, the Credit Agreement contains customary events of default. If an event of default occurs and is continuing, we may be required to immediately repay all amounts outstanding under the Credit Agreement, and the commitments under the Credit Agreement may be terminated.

As of March 31, 2011, the credit facility has not been drawn upon and we remain in compliance with all covenants.

#### *Auction Rate Securities*

As of March 31, 2011, \$42.7 million of our long-term investments were comprised of municipal note investments with an auction reset feature ("auction rate securities"). These notes are issued by various state and local municipal entities for the purpose of financing student loans, public projects and other activities, which carry investment grade credit ratings. As of the date of this 2011 Form 10-Q, auctions for all of our auction rate securities have failed and there is no assurance that auctions on the remaining auction rate securities in our investment portfolio will succeed in the future. An auction failure means that the parties wishing to sell their securities could not be matched with an adequate volume of buyers. In the event that there is a failed auction the indenture governing the security requires the issuer to pay interest at a contractually defined rate that is generally above market rates for other types of similar instruments. The securities for which auctions have failed will continue to accrue interest at the contractual rate and be auctioned every seven, 14, 28 or 35 days until the auction succeeds, the issuer calls the securities, or they mature. As a result, our ability to liquidate and fully recover the carrying value of our remaining auction rate securities in the near term may be limited or non-existent. In addition, while all of our auction rate securities currently carry investment grade ratings, if the issuers are unable to successfully close future auctions and their credit ratings deteriorate, we may in the future be required to record an impairment charge on these investments.

Although auctions continue to fail, we currently believe these securities are not impaired, primarily due to our ability and present intent to hold these securities until maturity or market stability is restored and because of government guarantees or municipal bond insurance. However, it could take until the final maturity of the underlying securities to realize our investments' recorded value. There were no sales or redemptions of such securities during the three months ended March 31, 2011.

## Overview of Cash Flow Activities

For the three months ended March 31, 2011 and 2010 our cash flows are summarized as follows:

|   | For the Three Months Ended<br>March 31, |            |
|---|---|------------|
|   | 2011                                    | 2010       |
|   | (In millions)                           |            |
| Net cash used in operations                         | \$ (43.9)                               | \$ (170.5) |
| Net cash (used in) provided by investing activities | (120.4)                                 | 8.0        |
| Net cash provided by financing activities           | 37.7                                    | 31.7       |

### Cash used in Operations

We generally receive premiums in advance of payments of claims for health care services; however, cash flows related to our operations can fluctuate significantly in a particular period depending on the timing of receipts for premiums from our government partners or payments related to resolving government investigations and related litigation. For the three months ended March 31, 2011, cash used in operations primarily consisted of an increase in premiums receivable of \$62.4 million, a \$52.5 million payment related to the investigation resolution and \$43.5 million of payments on accounts payable and other accrued expenses, partially offset by an increase in medical benefits payable of \$47.6 million and \$17.1 million in unearned premiums.

Cash flows from operations have substantially improved when compared to the prior year since 2010 activity reflects the pay down of remaining outstanding claims associated with our exit from PFFS.

### Cash (used in) provided by Investing Activities

During the three months ended March 31, 2011, cash used in investing activities primarily reflects our investment into higher yielding investment alternatives which had a net impact totaling approximately \$113.3 million and purchases of property and equipment totaling approximately \$8.7 million, partially offset by \$1.5 million of proceeds from the maturities of restricted investments net of purchases.

### Cash provided by Financing Activities

Included in financing activities are funds held for the benefit of members, which increased approximately \$37.8 million as of March 31, 2011. These funds represent reinsurance and low-income cost subsidies funded by CMS in connection with the Medicare Part D program, for which we assume no risk.

## Critical Accounting Estimates

In the ordinary course of business, we make a number of estimates and assumptions relating to the reporting of our results of operations and financial condition in conformity with accounting principles generally accepted in the United States (“GAAP”). We base our estimates on historical experience and on various other assumptions that we believe to be reasonable under the circumstances. Actual results could differ significantly from those estimates under different assumptions and conditions. We believe that our accounting estimates relating to premium revenue recognition, medical benefits expense and medical benefits payable, and goodwill and intangible assets, are those that are most important to the portrayal of our financial condition and results and require management’s most difficult, subjective and complex judgments, often as a result of the need to make estimates about the effect of matters that are inherently uncertain. We have not changed our methodology in deriving these critical accounting estimates from those previously disclosed in our Annual Report on Form 10-K (“2010 Form 10-K”). Our critical accounting estimates relating to premium revenue recognition, medical benefits payable and medical benefits expense, and the quantification of the sensitivity of financial results to reasonably possible changes in underlying assumptions used in such estimation, as well as assumptions relating to our impairment assessment of goodwill and intangible assets as of March 31, 2011, is discussed below.

### Premium Revenue Recognition

We receive premiums from state and federal agencies for the members that are assigned to, or have selected, us to provide health care services under Medicaid and Medicare. The premiums we receive for each member vary according to the specific government program and are generally determined at the beginning of the contract period. These premiums are subject to adjustment throughout the term of the contract by CMS and the states, although such adjustments are typically made at the commencement of each new contract renewal period.

We recognize premium revenues in the period in which we are obligated to provide services to our members. Premiums are billed monthly for coverage in the following month and we are paid generally in the month in which we provide services. We estimate, on an ongoing basis, the amount of member billings that may not be fully collectible or that will be returned based on historical trends, compliance with requirements for certain contracts to expend a minimum percentage of premiums on eligible medical expense, and other factors. An allowance is established for the estimated amount that may not be collectible and a liability is established for premium expected to be returned. Historically, the allowance has not been significant relative to premium revenue.

Premium payments that we receive are based upon eligibility lists produced by the government. We verify these lists to determine whether we have been paid for the correct premium category and program. From time to time, the states or CMS require us to reimburse them for premiums that we received based on an eligibility list that a state, CMS or we later discover, through our audits or otherwise, contains individuals who were not eligible for any government-sponsored program or belong to a different plan other than ours. The verification and subsequent membership changes may result in additional amounts due to us or we may owe premiums back to the government. The amounts receivable or payable identified by us through reconciliation and verification of agency eligibility lists relate to current and prior periods. The amounts receivable from government agencies for reconciling items were \$11.9 million and \$0.3 million at March 31, 2011 and December 31, 2010, respectively. The amounts due to government agencies for reconciling items were \$48.6 million and \$63.3 million at March 31, 2011 and December 31, 2010, respectively. We record adjustments to revenues based on member retroactivity. These adjustments reflect changes in the number and eligibility status of enrollees subsequent to when revenue was billed. We estimate the amount of outstanding retroactivity adjustments each period and adjust premium revenue accordingly; if appropriate, the estimates of retroactivity adjustments are based on historical trends, premiums billed, the volume of member and contract renewal activity and other information. Changes in member retroactivity adjustment estimates had a minimal impact on premiums recorded during the periods presented. Our government contracts establish monthly rates per member that may be adjusted based on member demographics such as age, working status or medical history.

#### *Minimum loss ratio requirement*

Certain of our Medicaid contracts require us to expend a minimum percentage of premiums on eligible medical expense ("minimum loss ratio requirement"), and to the extent that we expend less than the minimum loss ratio requirement, we are required to refund all or some portion of the difference between the minimum and our actual allowable medical expense. We estimate the amounts due to the state as a return of premium each period based on the terms of our contract with the applicable state agency, and such amounts are included in our results of operations as adjustments to premium revenues.

#### *Risk corridor*

The amount of premium relating to PDP coverage is subject to adjustment, positive or negative, based upon the application of risk corridors that compare our prescription drug costs estimated in our bids to CMS to our actual prescription drug costs. We estimate the amounts due to or from CMS for risk protection under the risk corridor provisions of our contract with CMS each period based on pharmacy claims experience to date as if the annual contract were to terminate at the end of the reporting period, and such amounts are included in our results of operations as adjustments to premium revenues.

#### *Risk-Adjusted Premiums*

CMS employs a risk-adjustment model to determine the premium amount it pays for each member. This model apportions premiums paid to all MA plans according to the health status of each beneficiary enrolled. As a result, our CMS monthly premium payments per member may change materially, either favorably or unfavorably. The CMS risk-adjustment model pays more for Medicare members with predictably higher costs. Diagnosis data from inpatient and ambulatory treatment settings are used to calculate the risk-adjusted premiums we receive. We collect claims and encounter data and submit the necessary diagnosis data to CMS within prescribed deadlines. After reviewing the respective submissions, CMS establishes the premium payments to MA plans generally at the beginning of the calendar year, and then adjusts premium levels on two separate occasions on a retroactive basis. The first retroactive adjustment for a given fiscal year generally occurs during the third quarter of such fiscal year. This initial settlement (the "Initial CMS Settlement") represents the updating of risk scores for the current year based on the severity of claims incurred in the prior fiscal year. CMS then issues a final retroactive risk-adjusted premium settlement for that fiscal year in the following year (the "Final CMS Settlement"). We reassess the estimates of the Initial CMS Settlement and the Final CMS Settlement each reporting period and any resulting adjustments are made to MA premium revenue.

We develop our estimates for risk-adjusted premiums utilizing historical experience and predictive models as sufficient member risk score data becomes available over the course of each CMS plan year. Our models are populated with available risk score data on our members. Risk premium adjustments are based on member risk score data from the previous year. Risk score data for members who entered our plans during the current plan year, however, is not available for use in our models; therefore, we make assumptions regarding the risk scores of this subset of our member population. All such estimated amounts are periodically updated as additional diagnosis code information is reported to CMS and adjusted to actual amounts when the ultimate adjustment settlements are either received from CMS or we receive notification from CMS of such settlement amounts.

As a result of the variability of factors that determine such estimates, including plan risk scores, the actual amount of CMS retroactive payment could be materially more or less than our estimates. Consequently, our estimate of our plans' risk scores for any period, and any resulting change in our accrual of MA premium revenues related thereto, could have a material adverse effect on our results of operations, financial position and cash flows. Historically, we have not experienced significant differences between the amounts that we have recorded and the revenues that we ultimately receive. The data provided to CMS to determine the risk score is subject to audit by CMS even after the annual settlements occur. These audits may result in the refund of premiums to CMS previously received by us. While our experience to date has not resulted in a material refund, this refund could be significant in the future, which would reduce our premium revenue in the year that CMS determines repayment is required.

CMS has performed and continues to perform Risk Adjustment Data Validation ("RADV") audits of selected MA plans to validate the provider coding practices under the risk adjustment model used to calculate the premium paid for each MA member. Our Florida MA plan was selected by CMS for audit for the 2007 contract year and we anticipate that CMS will conduct additional audits of other plans and contract years on an ongoing basis. The CMS audit process selects a sample of 201 enrollees for medical record review from each contract selected. We have responded to CMS's audit requests by retrieving and submitting all available medical records and provider attestations to substantiate CMS-sampled diagnosis codes. CMS will use this documentation to calculate a payment error rate for our Florida MA plan 2007 premiums. CMS has not indicated a schedule for processing or otherwise responding to our submissions.

CMS has indicated that payment adjustments resulting from its RADV audits will not be limited to risk scores for the specific beneficiaries for which errors are found, but will be extrapolated to the relevant plan population. In December 2010, CMS issued a draft audit sampling and payment error calculation methodology that it proposes to use in conducting these audits. CMS invited public comment on the proposed audit methodology and announced in early February 2011 that it will revise its proposed approach based on the comments received. CMS has not given a specific timetable for issuing a final version of the audit sampling and payment error calculation methodology. Given that the RADV audit methodology is new and is subject to modification, there is substantial uncertainty as to how it will be applied to MA organizations like our Florida MA plan. At this time, we do not know whether CMS will require retroactive or subsequent payment adjustments to be made using an audit methodology that may not compare the coding of our providers to the coding of Original Medicare and other MA plan providers, or whether any of our other plans will be randomly selected or targeted for a similar audit by CMS. We are also unable to determine whether any conclusions that CMS may make, based on the audit of our plan and others, will cause us to change our revenue estimation process. Because of this lack of clarity from CMS, we are unable to estimate with any reasonable confidence a coding or payment error rate or predict the impact of extrapolating an applicable error rate to our Florida MA plan 2007 premiums. However, it is likely that a payment adjustment will occur as a result of these audits, and that any such adjustment could have a material adverse effect on our results of operations, financial position, and cash flows, possibly in 2011 and beyond.

### *Estimating Medical Benefits Payable and Medical Benefits Expense*

The cost of medical benefits is recognized in the period in which services are provided and includes an estimate of the cost of IBNR medical benefits. Medical benefits payable has two main components: direct medical expenses and medically-related administrative costs. Direct medical expenses include amounts paid or payable to hospitals, physicians and providers of ancillary services, such as laboratories and pharmacies. Medically-related administrative costs include items such as case and disease management, utilization review services, quality assurance and on-call nurses, which are recorded in Selling, general, and administrative expense. Medical benefits payable on our Consolidated Balance Sheets represents amounts for claims fully adjudicated awaiting payment disbursement and estimates for IBNR. The following table provides a reconciliation of the total medical benefits payable balances as of March 31, 2011 and December 31, 2010:

|                                       | <b>March 31,<br/>2011</b> | <b>% of<br/>Total</b> | <b>December 31,<br/>2010</b> | <b>% of<br/>Total</b> |
|---------------------------------------|---------------------------|-----------------------|------------------------------|-----------------------|
|                                       | (in millions)             |                       | (in millions)                |                       |
| Claims adjudicated, but not yet paid  | \$ 78.0                   | 10%                   | \$ 50.9                      | 7%                    |
| IBNR                                  | 712.6                     | 90%                   | 692.1                        | 93%                   |
| <b>Total medical benefits payable</b> | <b>\$ 790.6</b>           |                       | <b>\$ 743.0</b>              |                       |

The medical benefits payable estimate has been, and continues to be, our most significant estimate included in our financial statements. We historically have used and continue to use a consistent methodology for estimating our medical benefits expense and medical benefits payable. Our policy is to record management's best estimate of medical benefits payable based on the experience and information available to us at the time. This estimate is determined utilizing standard actuarial methodologies based upon historical experience and key assumptions consisting of trend factors and completion factors using an assumption of moderately adverse conditions, which vary by business segment. These standard actuarial methodologies include using, among other factors, contractual requirements, historic utilization trends, the interval between the date services are rendered and the date claims are paid, denied claims activity, disputed claims activity, benefits changes, expected health care cost inflation, seasonality patterns, maturity of lines of business and changes in membership.

The factors and assumptions described above that are used to develop our estimate of medical benefits expense and medical benefits payable inherently are subject to greater variability when there is more limited experience or information available to us. The ultimate claims payment amounts, patterns and trends for new products and geographic areas cannot be precisely predicted at their onset, since we, the providers and the members do not have experience in these products or geographic areas. Standard accepted actuarial methodologies, discussed above, would allow for this inherent variability. This can result in larger differences between the originally estimated medical benefits payable and the actual claims amounts paid. Conversely, during periods where our products and geographies are more stable and mature, we have more reliable claims payment patterns and trend experience. With more reliable data, we should be able to more closely estimate the ultimate claims payment amounts; therefore, we may experience smaller differences between our original estimate of medical benefits payable and the actual claim amounts paid.

In developing our estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For the more recent months, which constitute the majority of the amount of the medical benefits payable, we estimate claims incurred by applying observed trend factors to the fixed fee per-member per-month ("PMPM") costs for prior months, which costs have been estimated using completion factors, in order to estimate the PMPM costs for the most recent months. We validate our estimates of the most recent PMPM costs by comparing the most recent months' utilization levels to the utilization levels in prior months and actuarial techniques that incorporate a historical analysis of claim payments, including trends in cost of care provided and timeliness of submission and processing of claims.

Many aspects of the managed care business are not predictable. These aspects include the incidences of illness or disease state (such as congestive heart failure cases, cases of upper respiratory illness, the length and severity of the flu season, diabetes, the number of full-term versus premature births and the number of neonatal intensive care babies). Therefore, we must continually monitor our historical experience in determining our trend assumptions to reflect the ever-changing mix, needs and size of our membership. Among the factors considered by management are changes in the level of benefits provided to members, seasonal variations in utilization, identified industry trends and changes in provider reimbursement arrangements, including changes in the percentage of reimbursements made on a capitation as opposed to a fee-for-service basis. These considerations are reflected in the trends in our medical benefits expense. Other external factors such as government-mandated benefits or other regulatory changes, catastrophes and epidemics may impact medical cost trends. Other internal factors such as system conversions and claims processing interruptions may impact our ability to accurately predict estimates of historical completion factors or medical cost trends. Medical cost trends potentially are more volatile than other segments of the economy. Management uses considerable judgment in determining medical benefits expense trends and other actuarial model inputs. We believe that the amount of medical benefits payable as of March 31, 2011 is adequate to cover our ultimate liability for unpaid claims as of that date; however, actual payments may differ from established estimates. If the completion factors we used in estimating our IBNR for the three months ended March 31, 2011 were decreased by 1%, our net income would decrease by approximately \$20.2 million. If the completion factors were increased by 1%, our net income would increase by approximately \$19.6 million.

We record reserves for estimated referral claims related to health care providers under contract with us who are financially troubled or insolvent and who may not be able to honor their obligations for the costs of medical services provided by other providers. In these instances, we may be required to honor these obligations for legal or business reasons. Based on our current assessment of providers under contract with us, such losses have not been and are not expected to be significant.

Changes in medical benefits payable estimates are primarily the result of obtaining more complete claims information and medical expense trend data over time. Volatility in members' needs for medical services, provider claims submissions and our payment processes result in identifiable patterns emerging several months after the causes of deviations from assumed trends occur. Since our estimates are based upon PMPM claims experience, changes cannot typically be explained by any single factor, but are the result of a number of interrelated variables, all influencing the resulting medical cost trend. Differences in our financial statements between actual experience and estimates used to establish the liability, which we refer to as prior period developments, are recorded in the period when such differences become known, and have the effect of increasing or decreasing the reported medical benefits expense and resulting MBR in such periods.

In establishing our estimate of reserves for IBNR at each reporting period, we use standard actuarial methodologies based upon historical experience and key assumptions consisting of trend factors and completion factors, which vary by business segment, to determine an estimate of the base reserve. Actuarial standards of practice require that a margin for uncertainty be considered in determining the estimate for unpaid claim liabilities. If a margin is included, the claim liabilities should be adequate under moderately adverse conditions. Therefore, we make an additional estimate in the process of establishing the IBNR, which also uses standard actuarial techniques, to account for adverse conditions that may cause actual claims to be higher than estimated compared to the base reserve, for which the model is not intended to account. We refer to this additional liability as the provision for moderately adverse conditions. The provision for moderately adverse conditions is a component of our overall determination of the adequacy of our IBNR reserve. The provision for moderately adverse conditions is intended to capture the potential adverse development from factors such as our entry into new geographical markets, our provision of services to new populations such as the aged, blind and disabled, the variations in utilization of benefits and increasing medical cost, changes in provider reimbursement arrangements, variations in claims processing speed and patterns, claims payment, the severity of claims, and outbreaks of disease such as the flu. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNR after considering the base actuarial model reserves and the provision for moderately adverse conditions. We consistently apply our IBNR estimation methodology from period to period. We review our overall estimates of IBNR on a monthly basis. As additional information becomes known to us, we adjust our assumptions accordingly to change our estimate of IBNR. Therefore, if moderately adverse conditions do not occur, evidenced by more complete claims information in the following period, then our prior period estimates will be revised downward, resulting in favorable development. However, any favorable prior period reserve development would affect (increase) current period net income only to the extent that the current period provision for moderately adverse conditions is less than the benefit recognized from the prior period favorable development. If moderately adverse conditions occur and are more than we estimated, then our prior period estimates will be revised upward, resulting in unfavorable development, which would decrease current period net income.

Medical benefits expense for the three months ended March 31, 2011, was impacted by approximately \$51.0 million of net favorable development related to prior years. For the three months ended March 31, 2010, medical benefits expense was impacted by approximately \$4.6 million of net favorable development related to prior years. The net favorable prior year development in 2011 results primarily from the difference between actual medical utilization compared to original assumptions and prior year claims estimates being settled for amounts that are different than originally anticipated. The net amount of prior period developments in the 2010 was primarily attributable to the reduction of the provision for moderately adverse conditions resulting from the exit of the PFFS product on December 31, 2009. The factors impacting the changes in the determination of medical benefits payable discussed above were not discernable in advance. The impact became clearer over time as claim payments were processed and more complete claims information was obtained.

### ***Goodwill and Intangible Assets***

We use a two-step process to review goodwill for impairment. The first step is a screen for potential impairment, and the second step measures the amount of impairment, if any. We review goodwill and intangible assets for potential impairment at least annually, or more frequently if events or changes in circumstances occur that may affect the estimated useful life or the recoverability of the remaining balance of goodwill or intangible assets. Events or changes in circumstances would include significant changes in membership, state funding, medical contracts and provider networks. We evaluate the potential impairment of goodwill and intangible assets using both the income and market approach. In doing so, we must

make assumptions and estimates, such as the discount factor and peer benchmarking, in estimating fair values. While we believe these assumptions and estimates are appropriate, other assumptions and estimates could be applied and might produce significantly different results. An impairment loss is recognized for goodwill and intangible assets if the carrying value of such assets exceeds its fair value. We select the second quarter of each year for our annual impairment test, which generally coincides with the finalization of federal and state contract negotiations and our initial budgeting process. As of our last impairment test as of June 30, 2010, we assessed the book value of goodwill and other intangible assets and determined that the fair value of these assets exceeds its carrying value and noted no indications that would require additional impairment testing as of March 31, 2011.

We also evaluate the intangible assets used in our PFFS business, which primarily consisted of state licenses for the insurance companies that underwrote that line of business. As we continue to use these company licenses for other lines of business and the licenses have a market value, we determined that these assets were not impaired.

### **Item 3. Quantitative and Qualitative Disclosures about Market Risk.**

As of March 31, 2011, we had cash and cash equivalents of \$1,232.9 million, investments classified as current assets of \$201.9 million, long-term investments of \$83.7 million and restricted investments on deposit for licensure of \$105.8 million. The short-term investments classified as current assets consist of highly liquid securities with maturities between three and twelve months and longer term bonds with floating interest rates that are considered available for sale. Restricted assets consist of cash and cash equivalents and U.S. Treasury instruments deposited or pledged to state agencies in accordance with state rules and regulations. These restricted assets are classified as long-term regardless of the contractual maturity date due to the nature of the states' requirements. The investments classified as long term are subject to interest rate risk and will decrease in value if market rates increase. Because of their contractual maturity dates, however, we would not expect the value of these investments to decline significantly as a result of a sudden change in market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at March 31, 2011, the fair value of our fixed income investments would decrease by approximately \$1.5 million. Similarly, a 1% decrease in market interest rates at March 31, 2011 would increase the fair value of our investments by approximately \$2.0 million.

### **Item 4. Controls and Procedures.**

#### ***Evaluation of Disclosure Controls and Procedures***

Our management carried out an evaluation required by Rule 13a-15 under the Exchange Act, under the leadership and with the participation of our President and Chief Executive Officer ("CEO") and Chief Financial Officer ("CFO"), of the effectiveness of our disclosure controls and procedures as defined in Rule 13a-15 under the Exchange Act ("Disclosure Controls"). Based on the evaluation, our CEO and CFO concluded that our Disclosure Controls were effective as of the end of the period covered by this Quarterly Report.

#### ***Changes in Internal Control over Financial Reporting***

There has not been any change in our internal control over financial reporting (as defined in Rule 13a-15(f) of the Exchange Act) identified in connection with the evaluation required by Rule 13a-15(d) under the Exchange Act during the quarter ended March 31, 2011 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

## Part II – OTHER INFORMATION

### Item 1. Legal Proceedings.

#### Government Investigations

##### *Civil Division of the United States Department of Justice*

On April 26, 2011, the Company entered into certain settlement agreements, described below, which will resolve the pending inquiries of the Civil Division of the United States Department of Justice (the “Civil Division”), the USAO and the United States Attorney’s Office for the District of Connecticut (the “USAO Connecticut”). These settlement agreements are related to four federal *qui tam* complaints filed by relators against WellCare under the whistleblower provisions of the False Claims Act, 31 U.S.C. sections 3729-3733 as well as one state *qui tam* action filed in Leon County, Florida (the “Leon County Action”), which is similar to one of the federal *qui tam* complaints. In connection with the execution of these settlement agreements, one of the federal *qui tam* actions, which had been filed in the District of Connecticut, was recently unsealed on April 29, 2011. The other three federal *qui tam* actions, which are pending in the Middle District of Florida, had been unsealed in June 2010. Additionally, the Leon County Action was unsealed on April 28, 2011.

The settlement agreements are with (a) the United States, with signatories from the Civil Division, the Office of Inspector General of the Department of Health and Human Services (“OIG-HHS”) and the Civil Divisions of the USAO and the USAO Connecticut (the “Federal Settlement Agreement”) and (b) the following states (collectively, the “Settling States”): Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Missouri, New York and Ohio (collectively, the “State Settlement Agreements”). The material terms of the Federal Settlement Agreement and the State Settlement Agreements are, collectively, substantively the same as the terms of the previously disclosed preliminary settlement with the Civil Division, the USAO and the USAO Connecticut. We have agreed, among other things, to pay the Civil Division a total of \$137.5 million (the “Settlement Amount”), which is to be paid in installments over a period of up to 36 months after the date of the Federal Settlement Agreement (the “Payment Period”) plus interest at the rate of 3.125% per year. The settlement includes an acceleration clause that would require immediate payment of the remaining balance of the Settlement Amount in the event that the Company is acquired or otherwise experiences a change in control during the Payment Period. In addition, the settlement provides for a contingent payment of an additional \$35 million in the event that the Company is acquired or otherwise experiences a change in control within three years of the execution of the Federal Settlement Agreement and provided that the change in control transaction exceeds certain minimum transaction value thresholds as specified in the Federal Settlement Agreement.

In exchange for the payment of the Settlement Amount, the United States and the Settling States agree to release us from any civil or administrative monetary claim under the False Claims Act and certain other legal theories for certain conduct that was at issue in their inquiries and the *qui tam* complaints. Likewise, in consideration of the obligations in the Federal Settlement Agreement and the Corporate Integrity Agreement (as described below under *United States Department of Health and Human Services*), OIG-HHS agrees to release and refrain from instituting, directing or maintaining any administrative action seeking to exclude us from Medicare, Medicaid and other federal health care programs.

The Federal Settlement Agreement has not been executed by one of the relators. Under its terms, this failure to timely execute is deemed to be an objection to the Federal Settlement Agreement. In the case of an objection, the Federal Court is required to conduct a hearing (a “Fairness Hearing”) to determine whether the proposed settlement is fair, adequate and reasonable under all the circumstances. The Federal Settlement Agreement and the State Settlement Agreements will not be effective until the earlier of (a) the execution of the Federal Settlement Agreement by the objecting relator or (b) entry by the Federal Court of a final order determining that the settlement is fair, adequate and reasonable under all the circumstances.

We can make no assurances that the objecting relator will execute the Federal Settlement Agreement or that the Federal Court will approve the settlement at a Fairness Hearing and the actual outcome of these matters may differ materially from the terms of the settlement.

##### *United States Department of Health and Human Services*

On April 26, 2011, the Company entered into a Corporate Integrity Agreement (the “Corporate Integrity Agreement”) with OIG-HHS. The Corporate Integrity Agreement has a term of five years and concludes the previously disclosed matters relating to the Company under review by OIG-HHS.

The Corporate Integrity Agreement formalizes various aspects of the Company's ethics and compliance program and contains other requirements designed to help ensure the Company's ongoing compliance with Federal health care program requirements. The terms of the Corporate Integrity Agreement include certain organizational structure requirements, internal monitoring requirements, compliance training, screening processes for new employees, reporting requirements to OIG-HHS, and the engagement of an independent review organization to review and prepare written reports regarding, among other things, the Company's reporting practices and bid submissions to federal health care programs.

### **Class Action Complaints**

On May 4, 2011, the Federal Court entered an order (the "Approval Order") approving the Stipulation and Agreement of Settlement (the "Stipulation Agreement") entered into on December 17, 2010 by the Company and a group of five public pension funds appointed by the Federal Court to act as lead plaintiffs in the consolidated securities class action *Eastwood Enterprises, L.L.C. v. Farha, et al.*, Case No. 8:07-cv-1940-VMC-EAJ. The Federal Court had preliminarily approved the Stipulation Agreement on February 9, 2011. Subsequently, notice was sent to all class members, and other legally required procedural steps were taken, in advance of the final approval hearing, which was held May 4, 2011.

In March 2011 the Company paid \$52.5 million into an escrow account for the benefit of the class pursuant to the Stipulation Agreement. As previously disclosed, the Stipulation Agreement also provides, among other things, that the Company will make an additional cash payment to the class of \$35.0 million by July 31, 2011 (the "July 2011 Payment"). It also requires, among other things, that the Company issue to the class tradable unsecured subordinated notes having an aggregate face value of \$112.5 million, with a fixed coupon of 6% and a maturity date of December 31, 2016. Additionally, the Company will be required to pay to the class an additional \$25.0 million if the Company experiences a change in control at a share price of \$30 or more within three years of the date of the Stipulation Agreement.

With respect to the July 2011 Payment and as required by the Stipulation Agreement, by May 9, 2011, the Company is required to deliver to the escrow agent for the class a non-negotiable promissory note in the principal amount of \$35 million (the "Note"). The Note is due and payable in full on July 31, 2011. The unpaid principal amount of the Note will accelerate and become immediately due and payable in the event of the Company's insolvency, a general assignment for the benefit of creditors, or the commencement by or against the Company of any action seeking reorganization, liquidation, dissolution, or similar treatment of the Company's debts under any law relating to bankruptcy, relief of debtors or similar laws. The unpaid principal will also accelerate in the event the Company or any third party seeks the appointment of a receiver or other similar official for the Company or its assets which, in the case of involuntary proceedings, has not been withdrawn or dismissed within 60 days after the filing of such proceeding. If the Company fails to pay the Note in full by July 31, 2011, then interest on the unpaid balance shall accrue at the rate and pursuant to the method set forth in 28 USC §1961 until all sums due are paid. In the event the payment is accelerated as described in the previous paragraph, then such interest will begin to accrue upon such acceleration.

### **Derivative Lawsuits**

As previously disclosed, putative derivative actions were filed in connection with our government investigations naming the Company as a nominal defendant. As previously disclosed, the Federal Court approved a Stipulation of Partial Settlement ("Stipulation I") and granted our motion to dismiss the director defendants and realigned us as the plaintiff in this action. The case is now styled *WellCare v. Farha, et al.* In August 2010, Messrs. Farha, Behrens and Bereday filed a notice of appeal in the United States Court of Appeals for the Eleventh Circuit (the "Court of Appeals"). As previously disclosed, the Circuit Court for Hillsborough County, Florida (the "State Court") approved a second Stipulation of Partial Settlement ("Stipulation II") and granted our motion to dismiss the director defendants and realigned us as the plaintiff in this action. In July 2010, Mr. Farha filed a notice of appeal in this matter. In October 2010, we filed a motion for leave to file an amended complaint against Mr. Farha in the State Court action and a new lawsuit in Federal Court against Messrs. Behrens and Bereday, stating claims for breach of contract and breach of their fiduciary duties. In April 2011, both the Federal Court and the State Court stayed these actions pending the conclusion of parallel federal criminal proceedings against Messrs. Farha, Behrens and Bereday.

**Item 1A. Risk Factors.**

Set forth below are material updates to the risk factors disclosed in Part I – Item 1A – *Risk Factors* included in our 2010 Form 10-K.

**Failure to comply with the terms of our government contracts could negatively impact our profitability and subject us to fines, penalties and liquidated damages or the termination of our contract.**

We contract with various governmental agencies to provide managed health care services. These contracts contain certain provisions regarding data submission, provider network maintenance, quality measures, continuity of care, call center performance and other requirements specific to program regulations. If we fail to comply with these requirements, we may be subject to fines, penalties and liquidated damages that could impact our profitability. If we fail to comply repeatedly over an extended time period, the applicable contract may be subject to termination. We anticipate that we may not meet the performance requirements of our contracts to provide services under the New York Medicaid Managed Care / Family Health Plus programs for the third consecutive year. If the state determines that we have failed to meet the contractual requirements, these contracts will be subject to termination, or other remedies, at the discretion of the state. We are unable to predict what actions that state may take, if any, when assessing our contractual performance.

Additionally, we could be required to file a corrective plan of action with the state and we could be subject to fines, penalties and liquidated damages and additional corrective action measures if we do not comply with the corrective plan of action. Our failure to comply could also affect future membership enrollment levels and our ability to compete for new business. These limitations could negatively impact our revenues and operating results.

Under the terms of our contracts with state governmental agencies, 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 any of the following: refunds to state government agencies of premiums we have been paid pursuant to our contracts; imposition of fines, penalties and other sanctions; loss of our right to participate in various markets; or loss of one or more of our licenses. Any such action could negatively impact our revenues and operating results.

**Item 2. Unregistered Sales of Equity Securities and Use of Proceeds.***Recent Sales of Unregistered Securities*

We did not sell any securities in the three months ended March 31, 2011 that were not registered under the Securities Act of 1933, as amended.

*Issuer Purchases of Equity Securities*

We do not have a stock repurchase program. However, during the quarter ended March 31, 2011, certain of our employees were deemed to have surrendered shares of our common stock to satisfy their tax withholding obligations associated with the vesting of shares of restricted common stock. The following table summarizes these repurchases:

| <b>Period</b>                              | <b>Total<br/>Number<br/>of Shares<br/>Purchased(1)</b> | <b>Average<br/>Price Paid<br/>Per Share(1)</b> | <b>Total<br/>Number<br/>of Shares<br/>Purchased<br/>as<br/>Part of<br/>Publicly<br/>Announced<br/>Plans or<br/>Programs</b> | <b>Maximum<br/>Number of<br/>Shares<br/>that<br/>May Yet<br/>Be<br/>Purchased<br/>Under the<br/>Plans or<br/>Programs</b> |
|--|--|--|---|---|
| January 1, 2011 through January 31, 2011   | 862  | \$31.51 (2)                                    | N/A   | N/A   |
| February 1, 2011 through February 28, 2011 | 303  | \$35.22 (3)                                    | N/A   | N/A   |
| March 1, 2011 through March 31, 2011       | 5,592  | \$37.00 (4)                                    | N/A   | N/A   |
| Total during quarter ended March 31, 2011  | 6,757  | \$36.61 (5)                                    | N/A   | N/A   |

(1) The number of shares purchased represent the number of shares of our common stock deemed surrendered by our employees to satisfy their withholding tax obligations due to the vesting of shares of restricted common stock. For the purposes of this table, we determined the average price paid per share based on the closing price of our common stock as of the date of the determination of the withholding tax amounts (i.e., the date that the shares of restricted stock vested). We do not currently have a stock repurchase program. We did not pay any cash consideration to repurchase these shares.

(2) The weighted average price paid per share during the period was \$31.84.

(3) The weighted average price paid per share during the period was \$35.41.

- (4) The weighted average price paid per share during the period was \$37.42.
- (5) The weighted average price paid per share during the period was \$36.64.

## **Item 5. Other Information.**

### **Class Action Complaints**

On May 4, 2011, the United States District Court for the Middle District of Florida (the “Federal Court”) entered an order (the “Approval Order”) approving the Stipulation and Agreement of Settlement (the “Stipulation Agreement”) entered into on December 17, 2010 by the Company and a group of five public pension funds appointed by the Federal Court to act as lead plaintiffs in the consolidated securities class action *Eastwood Enterprises, L.L.C. v. Farha, et al.*, Case No. 8:07-cv-1940-VMC-EAJ. The Federal Court had preliminarily approved the Stipulation Agreement on February 9, 2011. Subsequently, notice was sent to all class members, and other legally required procedural steps were taken, in advance of the final approval hearing, which was held May 4, 2011.

In March 2011 the Company paid \$52.5 million into an escrow account for the benefit of the class pursuant to the Stipulation Agreement. As previously disclosed, the Stipulation Agreement also provides, among other things, that the Company will make an additional cash payment to the class of \$35.0 million by July 31, 2011 (the “July 2011 Payment”). It also requires, among other things, that the Company issue to the class tradable unsecured subordinated notes having an aggregate face value of \$112.5 million, with a fixed coupon of 6% and a maturity date of December 31, 2016. Additionally, the Company will be required to pay to the class an additional \$25.0 million if the Company experiences a change in control at a share price of \$30 or more within three years of the date of the Stipulation Agreement.

A copy of the Stipulation Agreement was attached as Exhibit 10.44 to the Company’s Annual Report on Form 10-K for the year ended December 31, 2010.

With respect to the July 2011 Payment and as required by the Stipulation Agreement, by May 9, 2011, the Company is required to deliver to the escrow agent for the class a non-negotiable promissory note in the principal amount of \$35 million (the “Note”). The Note is due and payable in full on July 31, 2011. The unpaid principal amount of the Note will accelerate and become immediately due and payable in the event of the Company’s insolvency, a general assignment for the benefit of creditors, or the commencement by or against the Company of any action seeking reorganization, liquidation, dissolution, or similar treatment of the Company’s debts under any law relating to bankruptcy, relief of debtors or similar laws. The unpaid principal will also accelerate in the event the Company or any third party seeks the appointment of a receiver or other similar official for the Company or its assets which, in the case of involuntary proceedings, has not been withdrawn or dismissed within 60 days after the filing of such proceeding.

If the Company fails to pay the Note in full by July 31, 2011, then interest on the unpaid balance shall accrue at the rate and pursuant to the method set forth in 28 USC §1961 until all sums due are paid. In the event the payment is accelerated as described in the previous paragraph, then such interest will begin to accrue upon such acceleration.

### **Item 6. Exhibits.**

Exhibits are incorporated herein by reference or are filed with this report as set forth in the Exhibit Index on page 42 hereof.

## SIGNATURES

Pursuant to the requirements of the Securities and Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized in Tampa, Florida on May 6, 2011.

WELLCARE HEALTH PLANS, INC.

By: /s/ Thomas L. Tran  
Thomas L. Tran  
Senior Vice President and Chief Financial Officer (Principal Financial Officer)

By: /s/ Maurice S. Hebert  
Maurice S. Hebert  
Chief Accounting Officer (Principal Accounting Officer)