CENTENE CORP
Form 10-K
February 21, 2014

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K
(Mark One)
x ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2013
or
o TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to
Commission file number: 001-31826
Centene Corporation
(Exact name of registrant as specified in its charter)

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

Registrant's telephone number, including area code: (314) 725-4477
Securities registered pursuant to Section 12(b) of the Act:

Common Stock, $0.001 Par Value	New York Stock Exchange
Title of Each Class	Name of Each Exchange on Which Registered

Securities registered pursuant to Section 12(g) of the Act:
None
(Title of Each Class)
Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes x No o
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes o No x
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 x No o
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 require to submit and post such files). Yes x No o
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. o
Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of “large accelerated filer”, “accelerated filer” and “small reporting

company” in Rule 12b-2 of the Exchange Act.

x Large accelerated filer o Accelerated filer

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

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 28, 2013, was $2.9 billion.

As of February 14, 2014, the registrant had 57,615,380 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2014 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

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CAUTIONARY STATEMENT ON FORWARD-LOOKING STATEMENTS

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

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

- our ability to accurately predict and effectively manage health benefits and other operating expenses;
- competition;
- membership and revenue projections;
- timing of regulatory contract approval;
- changes in healthcare practices;
- changes in federal or state laws or regulations, including the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act and any regulations enacted thereunder;
- changes in expected contract start dates;
- changes in expected closing dates and accretion for acquisitions;
- inflation;
- provider and state contract changes;
- new technologies;
- advances in medicine;
- reduction in provider payments by governmental payors;
- major epidemics;
- disasters and numerous other factors affecting the delivery and cost of healthcare;
- the expiration, cancellation or suspension of our Medicare or Medicaid managed care contracts by federal or state governments;
- the outcome of pending legal proceedings;
- availability of debt and equity financing, on terms that are favorable to us; and
- general economic and market conditions.

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

Other Information

The discussion in Part 2, Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations" under the heading "Results of Operations" contains financial information for new and existing businesses. Existing businesses are primarily state markets, significant geographic expansion in an existing state or product that we have managed for four complete quarters. New businesses are primarily new state markets, significant geographic expansion in an existing state or product that conversely, we have not managed for four complete quarters.

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PART I

ITEM 1. Business.

OVERVIEW

We are a diversified, multi-line healthcare enterprise that provides programs and services to government sponsored healthcare programs, focusing on under-insured and uninsured individuals. We provide member-focused services through locally based staff by assisting in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services. We believe our local approach, including member and provider services, enables us to provide accessible, quality, culturally-sensitive healthcare coverage to our communities. Our health management, educational and other initiatives are designed to help members best utilize the healthcare system to ensure they receive appropriate, medically necessary services and effective management of routine, severe and chronic health problems, resulting in better health outcomes. We combine our decentralized local approach for care with a centralized infrastructure of support functions such as finance, information systems and claims processing.

We operate in two segments: Managed Care and Specialty Services. Our Managed Care segment provides health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program (CHIP), Long Term Care (LTC), Foster Care, dual-eligible individuals in Medicare Special Needs Plans and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program, or collectively ABD. Beginning in 2014, our Managed Care segment also provides health plan coverage to individuals covered through federally-facilitated and state-based Marketplaces. Our Specialty Services segment consists of our specialty companies offering diversified healthcare services and products to state programs, correctional facilities, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries. As of December 31, 2013, Medicaid accounted for 75% of our at-risk membership, while CHIP (also including Foster Care) and ABD (also including Medicare) accounted for 10% and 11%, respectively. Hybrid programs, LTC and correctional services represent the remaining 4% at-risk membership.

Our subsidiary, Kentucky Spirit Health Plan (KSHP), ceased serving Medicaid members in Kentucky as of July 6, 2013. Accordingly, the results of operations for KSHP are classified as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise identified.

Our at-risk managed care membership totaled 2.7 million as of December 31, 2013. For the year ended December 31, 2013, our premium and service revenues and net earnings from continuing operations attributable to Centene were $10.5 billion and $161.2 million, respectively, and our total cash flow from operations was $382.5 million.

Our initial health plan commenced operations in Wisconsin in 1984. We were organized in Wisconsin in 1993 as a holding company for our initial health plan and reincorporated in Delaware in 2001. Our corporate office is located at 7700 Forsyth Boulevard, St. Louis, Missouri 63105, and our telephone number is (314) 725-4477. Our stock is publicly traded on the New York Stock Exchange under the ticker symbol “CNC.”

INDUSTRY

We provide our services primarily through Medicaid, CHIP, LTC, Foster Care, ABD, Medicare and other state and federal programs for the uninsured. The federal Centers for Medicare and Medicaid Services, or CMS, estimated the total Medicaid and CHIP market was approximately $408 billion in 2011, and estimate the market will grow to $839 billion by 2022. According to the most recent information provided by the Kaiser Commission on Medicaid and the Uninsured, Medicaid spending increased by 3.8% in fiscal 2013 and states appropriated an increase of 10.3% for Medicaid in fiscal 2014 budgets.

Established in 1965, Medicaid is the largest publicly funded program in the United States, and provides health insurance to low-income families and individuals with disabilities. Authorized by Title XIX of the Social Security Act, Medicaid is an entitlement program funded jointly by the federal and state governments and administered by the states. The majority of funding is provided at the federal level. Each state establishes its own eligibility standards, benefit packages, payment rates and program administration within federal standards. As a result, there are 56 Medicaid programs - one for each U.S. state, each U.S. territory and the District of Columbia. Eligibility is based on a combination of household income and assets, often determined by an income level relative to the federal poverty level. Historically, children have represented the largest eligibility group. Many states have selected Medicaid managed care as a means of delivering quality healthcare and controlling costs. We refer to these states as mandated managed care states.

Established in 1972, and authorized by Title XVI of the Social Security Act, ABD covers low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries represent a growing portion of all Medicaid recipients. In addition, ABD recipients typically utilize more services because of their critical health issues.

The Balanced Budget Act of 1997 created CHIP to help states expand coverage primarily to children whose families earned too much to qualify for Medicaid, yet not enough to afford private health insurance. Some states include the parents of these children in their CHIP programs. Costs related to the largest eligibility group, children, are primarily composed of pediatrics and family care. These costs tend to be more predictable than those associated with other healthcare issues which predominantly affect the adult population.

A portion of Medicaid beneficiaries are dual-eligible, low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. According to the Kaiser Commission on Medicaid and the Uninsured, there were approximately 9 million dual-eligible enrollees in 2013. These dual-eligible members may receive assistance from Medicaid for Medicaid benefits, such as nursing home care and/or assistance with Medicare premiums and cost sharing. Dual-eligibles also use more services due to their tendency to have more chronic health issues. We serve dual-eligibles through our ABD and LTC programs and through Medicare Special Needs Plans.

While Medicaid programs have directed funds to many individuals who cannot afford or otherwise maintain health insurance coverage, they did not initially address the inefficient and costly manner in which the Medicaid population tends to access healthcare. Medicaid recipients in non-managed care programs typically have not sought preventive care or routine treatment for chronic conditions, such as asthma and diabetes. Rather, they have sought healthcare in hospital emergency rooms, which tends to be more expensive. As a result, many states have found that the costs of providing Medicaid benefits have increased while the medical outcomes for the recipients remained unsatisfactory.

We expect that continued pressure on state Medicaid budgets will cause public policy to recognize the value of managed care as a means of delivering improved health outcomes for Medicaid beneficiaries and effectively controlling costs. A growing number of states have mandated that their Medicaid recipients enroll in managed care plans. Other states are considering moving to a mandated managed care approach. As a result, we believe a significant market opportunity exists for managed care organizations with operations and programs focused on the distinct socio-economic, cultural and healthcare needs of the uninsured population and the Medicaid, CHIP, LTC, Foster Care and ABD populations.

In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act collectively referred to as the Affordable Care Act (ACA), were enacted. While the constitutionality of the ACA was subsequently challenged in a number of legal actions, in June 2012, the Supreme Court upheld the constitutionality of the ACA, with one limited exception relating to the Medicaid expansion provision. The Supreme Court held that states could not be required to expand Medicaid and risk losing all federal money for their existing Medicaid programs. Under the ACA, Medicaid coverage was expanded to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to the states' elections. The federal government will pay the entire costs for Medicaid coverage for newly eligible beneficiaries for 3 years, from 2014 through 2016. In 2017, the federal share declines to 95%; in 2018 it is 94%; in 2019 it is 93%; and it will be 90% in 2020 and subsequent years. States may delay Medicaid expansion after 2014.

Health Insurance Marketplaces are a key component of the ACA and provide an opportunity for individuals and small businesses to obtain health insurance. States have the option of operating their own Marketplace or partnering with the federal government. States choosing neither option will default to a federally-facilitated Marketplace. Premium and cost-sharing subsidies are available to make coverage more affordable and access to Marketplaces is limited to U.S. citizens and legal immigrants. Insurers are required to offer a minimum level of benefits with three levels of coverage that vary based on premiums and out-of-pocket costs. Premium subsidies will be provided to families without access to other coverage and with incomes between 100-400% of the federal poverty level to help them purchase insurance through the Marketplaces. These subsidies are offered on a sliding scale basis. In May 2013, the Congressional Budget Office (CBO) estimated approximately 7 million individuals would enroll through Marketplaces by 2014 with the number increasing to 25 million by 2025. However, recent reports have indicated lower than anticipated enrollment for 2014.

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OUR COMPETITIVE STRENGTHS

Our multi-line managed care approach is based on the following key attributes:

- Strong Historic Operating Performance. We have increased revenues as we have grown in existing markets, expanded into new markets and broadened our product offerings. We entered the Wisconsin market in 1984 as a single health plan and have grown to serve 20 states with at-risk membership totaling 2.7 million in 2013. For the year ended December 31, 2013, we had premium and service revenues from continuing operations of $10.5 billion, representing a five year Compound Annual Growth Rate, of 26.3% and generated total cash flow from operations of $382.5 million.

- Innovative Technology and Scalable Systems. The ability to access data and translate it into meaningful information is essential to operating across a multi-state service area in a cost-effective manner. Our centralized information systems support our core processing functions under a set of integrated databases and are designed to be both replicable and scalable to accommodate organic growth and growth from acquisitions. We continue to enhance our systems in order to leverage the platform we have developed for our existing states for configuration into new states or health plan acquisitions. Our predictive modeling technology enables our medical management operations to proactively case and disease manage specific high risk members. It can recommend medical care opportunities using a mix of company defined algorithms and evidence based medical guidelines. Interventions are determined by the clinical indicators, the ability to improve health outcomes, and the risk profile of members. Our integrated approach helps to assure that consistent sources of claim and member information are provided across all of our health plans. Our membership and claims processing system is capable of expanding to support additional members in an efficient manner.

- Medicaid Expertise. For more than 25 years, we have developed a specialized Medicaid expertise that has helped us establish and maintain relationships with members, providers and state governments. We have implemented programs developed to achieve savings for state governments and improve medical outcomes for members by reducing inappropriate emergency room use, inpatient days and high cost interventions, as well as by managing care of chronic illnesses. We work with state agencies in order to maximize the effectiveness of their programs. Our approach is to accomplish this while maintaining adequate levels of provider compensation and protecting our profitability.

- Diversified Business Lines. We continue to broaden our service offerings to address areas that we believe have been traditionally under-served by Medicaid managed care organizations. In addition to our Medicaid and Medicaid-related managed care services, our service offerings include behavioral health, care management software, correctional services managed care, Health Insurance Marketplaces, in-home health services, individual health insurance, life and health management, managed vision, telehealth services, pharmacy benefits management and specialty pharmacy. Through the utilization of a multi-business line approach, we are able to improve the quality of care, improve outcomes, diversify our revenues and help control our medical costs.

- Localized Approach with Centralized Support Infrastructure. We take a localized approach to managing our subsidiaries, including provider and member services. This approach enables us to facilitate access by our members to high quality, culturally sensitive healthcare services. Our systems and procedures have been designed to address these community-specific challenges through outreach, education, transportation and other member support activities. For example, our community outreach programs work with our members and their communities to promote health and self-improvement through employment and education on how best to access care. We complement this localized approach with a centralized infrastructure of support functions such as finance, information systems and claims processing, which allows us to minimize general and administrative expenses and to integrate and realize synergies from acquisitions. We believe this combined approach allows us to efficiently integrate new business opportunities in both Medicaid and specialty services while maintaining our local accountability and improved access.

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OUR BUSINESS STRATEGY

Our objective is to become the leading multi-line healthcare enterprise focusing on the uninsured and under-insured population through government sponsored healthcare initiatives. We intend to achieve this objective by implementing the following key components of our strategy:

- Increase Penetration of Existing State Markets. We seek to continue to increase our Medicaid membership in states in which we currently operate through alliances with key providers, outreach efforts, development and implementation of community-specific products and acquisitions. For example, in 2013, we expanded our health plan in Florida with an expanded Medicaid managed care LTC contract.

- Diversify Business Lines. We seek to broaden our business lines into areas that complement our existing business to enable us to grow and diversify our revenue. We are constantly evaluating new opportunities for expansion both domestically and abroad. For instance, in 2013, we began operating through a joint venture subsidiary, Centurion, to provide managed care in correctional facilities and also acquired AcariaHealth, an independent, comprehensive specialty pharmacy company. In 2014, we acquired U.S. Medical Management, a management services organization and provider of in-home health services for high acuity populations. We employ a disciplined acquisition strategy that is based on defined criteria including internal rate of return, accretion to earnings per share, market leadership and compatibility with our information systems. We engage our executives in the relevant operational units or functional areas to ensure consistency between the diligence and integration process.

- Address Emerging State Needs. We work to assist the states in which we operate in addressing the operating challenges they face. We seek to assist the states in balancing premium rates, benefit levels, member eligibility, policies and practices, provider compensation and minimizing fraud and abuse. By helping states structure an appropriate level and range of Medicaid, CHIP and specialty services, we seek to ensure that we are able to continue to provide those services on terms that achieve targeted gross margins, provide an acceptable return and grow our business.

- Develop and Acquire Additional State Markets. We continue to leverage our experience to identify and develop new markets by seeking both to acquire existing business and to build our own operations. We focus expansion in states where Medicaid recipients are mandated to enroll in managed care organizations because we believe member enrollment levels are more predictable in these states. In addition, we focus on states where managed care programs can help address states' financial needs. For example, in 2013, we began managing care for Medicaid members in California, Kansas and New Hampshire.

- Leverage Established Infrastructure to Enhance Operating Efficiencies. We intend to continue to invest in infrastructure to further drive efficiencies in operations and to add functionality to improve the service provided to members and other organizations at a low cost. Information technology, or IT, investments complement our overall efficiency goals by increasing the automated processing of transactions and growing the base of decision-making analytical tools. Our centralized functions and common systems enable us to add members and markets quickly and economically.

- Maintain Operational Discipline. We seek to operate in markets that allow us to meet our internal metrics including membership growth, plan size, market leadership and operating efficiency. We use multiple techniques to monitor and reduce our medical costs, including on-site hospital review by staff nurses and involvement of medical management in significant cases. Our executive dashboard is utilized to quickly identify cost drivers and medical trends. Our management team regularly evaluates the financial impact of proposed changes in provider relationships, contracts, changes in membership and mix of members, potential state rate changes and cost reduction initiatives. We may divest contracts or health plans in markets where the state's Medicaid environment, over a long term basis, does not allow us to meet our targeted performance levels. For example, as a result of lower than anticipated financial performance, in July 2013, we terminated our Kentucky Medicaid managed care contract with the Commonwealth of Kentucky.

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We have subsidiaries offering healthcare services in each state we serve. The table below provides summary data for the state markets we currently serve:

State	Local Plan Name	First Year of Operations Under the Company	Counties Served at December 31, 2013	Market Share [1]	At-risk Managed Care Membership at December 31, 2013
Arizona	Bridgeway Health Solutions	2006	6	11.2%	7,100
Arizona	Cenpatico Behavioral Health of Arizona	2005	8	13.3%	(2)
Arkansas	Arkansas Health and Wellness Solutions	2014	—	—%	—
California	California Health and Wellness	2013	19	56.2%	97,200
Florida	Sunshine Health	2009	53	13.3%[3]	222,000
Georgia	Peach State Health Plan	2006	159	27.6%	318,700
Illinois	IlliniCare Health Plan	2011	12	51.3%	22,300
Indiana	Managed Health Services	1995	92	27.3%	195,500
Kansas	Sunflower State Health Plan	2013	105	36.3%	139,900
Louisiana	Louisiana Healthcare Connections	2012	64	17.0%	152,300
Massachusetts	CeltiCare Health Plan	2009	14	5.2%	12,000
Massachusetts	Massachusetts Partnership for Correctional Healthcare	2013	N/A	N/A	10,600
Minnesota	Centurion of Minnesota	2014	—	—%	—
Mississippi	Magnolia Health Plan	2011	82	54.7%	78,300
Missouri	Home State Health Plan	2012	54	14.6%	59,200
New Hampshire	New Hampshire Healthy Families	2013	10	33.5%	33,600
Ohio	Buckeye Community Health Plan	2004	88	10.0%	173,200
South Carolina	Absolute Total Care	2007	39	14.0%	91,900
Tennessee	Centurion of Tennessee	2013	N/A	N/A	20,700
Texas	Superior HealthPlan	1999	254	26.0%	935,100
Washington	Coordinated Care	2012	39	10.2%	82,100
Wisconsin	Managed Health Services	1984	46	10.2%	71,500
					2,723,200

(1) Market share represents our % of the total at-risk members that are included in managed care programs in which we participate.

(2) Cenpatico Behavioral Health of Arizona provided behavioral health services for 156,600 members at December 31, 2013.

(3) Reflects Medicaid, ABD and CHIP programs. The Sunshine Health LTC program has a market share of 28.9%.

Substantially all of our revenue is derived from operations within the United States and its territories, and all of the Company's long lived assets are based in the United States and its territories. We generally receive a fixed premium per member per month pursuant to our state contracts. Our medical costs have a seasonality component due to cyclical illness, for example cold and flu season, resulting in higher medical expenses beginning in the fourth quarter and continuing throughout the first quarter of the following year. Our managed care subsidiaries in Texas had revenues from the state government that represent 37% of our consolidated total revenues from continuing operations in 2013.

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MANAGED CARE

Benefits to States

Our ability to establish and maintain a leadership position in the markets we serve results primarily from our demonstrated success in providing quality care while reducing and managing costs, and from our specialized programs in working with state governments. Among the benefits we are able to provide to the states with which we contract are:

- Significant cost savings and budget predictability compared to state paid reimbursement for services. We bring bottom-line management experience to our health plans. On the administrative and management side, we bring experience including quality of care improvement methods, utilization management procedures, an efficient claims payment system, and provider performance reporting, as well as managers and staff experienced in using these key elements to improve the quality of and access to care. We generally receive a contracted premium on a per member basis and are responsible for the medical costs and as a result, provide budget predictability.

- Data-driven approaches to balance cost and verify eligibility. We seek to ensure effective outreach procedures for new members, then educate them and ensure they receive needed services as quickly as possible. Our IT department has created mapping/translation programs for loading membership and linking membership eligibility status to all of Centene's subsystems. We utilize predictive modeling technology to proactively case and disease manage specific high risk members. In addition, we have developed Centelligence, our enterprise data warehouse system to provide a seamless flow of data across our organization, enabling providers and case managers to access information, apply analytical insight and make informed decisions.

- Establishment of realistic and meaningful expectations for quality deliverables. We have collaborated with state agencies in redefining benefits, eligibility requirements and provider fee schedules with the goal of maximizing the number of individuals covered through Medicaid.

- Managed care expertise in government subsidized programs. Our expertise in Medicaid has helped us establish and maintain strong relationships with our constituent communities of members, providers and state governments. We provide access to services through local providers and staff that focus on the cultural norms of their individual communities. To that end, systems and procedures have been designed to address community-specific challenges through outreach, education, transportation and other member support activities.

- Improved quality and medical outcomes. We have implemented programs developed to improve the quality of healthcare delivered to our members including Smart Start for your Baby, Living Well With Sickle Cell and The CentAccount Program.

- Timely payment of provider claims. We are committed to ensuring that our information systems and claims payment systems meet or exceed state requirements. We continuously endeavor to update our systems and processes to improve the timeliness of our provider payments.

- Provider outreach and programs. Our health plans have adopted a physician-driven approach where network providers are actively engaged in developing and implementing healthcare delivery policies and strategies. We prepare provider comparisons on a severity adjusted basis. This approach is designed to eliminate unnecessary costs, improve services to members and simplify the administrative burdens placed on providers.

- Responsible collection and dissemination of utilization data. We gather utilization data from multiple sources, allowing for an integrated view of our members' utilization of services. These sources include medical, vision and behavioral health claims and encounter data, pharmacy data, dental vendor claims and authorization data from the authorization and case management system utilized by us to coordinate care.

- Timely and accurate reporting. Our information systems have reporting capabilities which have been instrumental in identifying the need for new and/or improved healthcare and specialty programs. For state agencies, our reporting capability is important in demonstrating an auditable program.

- Fraud and abuse prevention. We have several systems in place to help identify, detect and investigate potential waste, abuse and fraud including pre and post payment review software. We collaborate with state and federal agencies and assist with investigation requests. We use nationally recognized standards to benchmark our processes.

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Member Programs and Services

We recognize the importance of member-focused delivery of quality managed care services. Our locally-based staff assists members in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. While covered healthcare benefits vary from state to state, our health plans generally provide the following services:

- primary and specialty physician care
- inpatient and outpatient hospital care
- emergency and urgent care
- prenatal care
- laboratory and x-ray services
- home health and durable medical equipment
- behavioral health and substance abuse services
- 24-hour nurse advice line

- transportation assistance
- vision care
- dental care
- immunizations
- prescriptions and limited over-the-counter drugs
- therapies
- social work services
- care coordination

We also provide the following education and outreach programs to inform, assist and incentivize members in accessing quality, appropriate healthcare services in an efficient manner. Many of these programs have been recognized with awards for their excellence in education, outreach and/or case management techniques including Case In Point, Hermes Awards, and National Health Information Awards.

- Start Smart For Your Baby, or Smart Start, is our award winning prenatal and infant health program designed to increase the percentage of pregnant women receiving early prenatal care, reduce the incidence of low birth weight babies, identify high-risk pregnancies, increase participation in the federal Women, Infant and Children program, prevent hospital admissions in the first year of life and increase well-child visits.

- Connections Plus is a cell phone program developed for high-risk members who have limited or no access to a safe, reliable telephone. This program seeks to eliminate lack of safe, reliable access to a telephone as a barrier to coordinating care, thus reducing avoidable adverse events such as inappropriate emergency room utilization, hospital admissions and premature birth.

- MemberConnections is a community face-to-face outreach and education program designed to create a link between the member and the provider and help identify potential challenges or risk elements to a member's health, such as nutritional challenges and health education shortcomings.

- Health Initiatives for Children is aimed at educating child members on a variety of health topics. In order to empower and educate children, we have partnered with a nationally recognized children's author to develop our own children's book series on topics such as obesity prevention and healthy eating, asthma, diabetes, foster care, the ills of smoking, anti-bullying and heart healthy.

- Health Initiatives for Teens is aimed at empowering, educating and reinforcing life skills with our teenage members. We have developed an educational series that addresses health issues, dealing with chronic diseases including diabetes and asthma, as well as teen pregnancy.

- Living Well with Sickle Cell is our innovative program that assists with coordination of care for our sickle cell members. Our program ensures that sickle cell members have established a medical home and work on strategies to reduce unnecessary emergency department (ED) visits through proper treatment to control symptoms and chronic complications, as well as promote self-management.

- My Route for Health is our adult educational series used with our case management and disease management programs. The topics of this series include how to manage asthma, COPD, diabetes, heart disease and HIV.

- Nurtur Diabetes Program is an innovative program that is a collaboration with our life and health management subsidiary, Nurtur Health, Inc., and our health plans that targets diabetic patients and educates them on their disease state.

- Community Health Record, our patient-centric electronic database, collects patient demographic data, clinician visit records, dispensed medications, vital sign history, lab results, allergy charts, and immunization data. Providers can directly input additional or updated patient data and documentation into the database. All information is accessible

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anywhere, anytime to all authorized users, including health plan staff, greatly facilitating coordinated care among providers.

- The CentAccount Program offers members financial incentives for performing certain healthy behaviors. The incentives are delivered through a restricted-use prepaid debit card redeemable for health-related items only. This incentive-based approach effectively increases the utilization of preventive services while strengthening the relationships between members and their primary care providers.

- The Asthma Management Program integrates a hands-on approach with a flexible outreach methodology that can be customized to suit different age groups and populations affected by asthma. Working through Nurtur, we provide proactive identification of members, stratification into appropriate levels of intervention including home visits, culturally sensitive education, and robust outcome reporting. The program also includes aggressive care coordination to ensure patients have basic services such as transportation to the doctor, electricity to power the nebulizer, and a clean, safe home environment.

- Fluvention is an outreach program aimed at educating members on preventing the transmission of the influenza virus by encouraging members to get the seasonal influenza vaccines and take everyday precautions to prevent illness.

- Preventive Care Programs are designed to educate our members on the benefits of Early and Periodic Screening, Diagnosis and Treatment, or EPSDT, services. We have a systematic program of communicating, tracking, outreach, reporting and follow-through that promotes state EPSDT programs.

- Life and Health Management Programs are designed to help members understand their disease and treatment plans and improve their wellness in a cost effective manner. These programs address medical conditions that are common within the Medicaid population such as asthma, diabetes and pregnancy.

Providers

For each of our service areas, we establish a provider network consisting of primary and specialty care physicians, hospitals and ancillary providers. As of December 31, 2013, we contracted with over 50,000 primary care physicians, 165,000 specialty care physicians and 2,000 hospitals.

Our network of primary care physicians is a critical component in care delivery, management of costs and the attraction and retention of new members. Primary care physicians include family and general practitioners, pediatricians, internal medicine physicians and obstetricians and gynecologists. Specialty care physicians provide medical care to members generally upon referral by the primary care physicians. Specialty care physicians include, but are not limited to, orthopedic surgeons, cardiologists and otolaryngologists. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services.

Our health plans facilitate access to healthcare services for our members primarily through contracts with our providers. Our contracts with primary and specialty care physicians and hospitals usually are for one to two-year periods and renew automatically for successive one-year terms, but generally are subject to termination by either party upon 90 to 120 days prior written notice. In the absence of a contract, we typically pay providers at state Medicaid reimbursement levels. We pay hospitals under a variety of methods, including fee-for-service, capitation arrangements, per diems, diagnostic related grouping and case rates. We pay physicians under a fee-for-service, capitation arrangement, or risk-sharing arrangement. In addition, we are governed by state prompt payment policies.

- Under our fee-for-service contracts with physicians, particularly specialty care physicians, we pay a negotiated fee for covered services. This model is characterized as having no financial risk for the physician. In addition, this model requires management oversight because our total cost may increase as the units of services increase or as more expensive services replace less expensive services. We have prior authorization procedures in place that are intended to make sure that certain high cost diagnostic and other services are medically appropriate.

- Under our capitated contracts, primary care physicians are paid a monthly fee for each of our members assigned to his or her practice for all ambulatory care. In return for this payment, these physicians provide all primary care and preventive services, including primary care office visits and EPSDT services, and are at risk for all costs associated with such services. If these physicians also provide non-capitated services to their assigned members, they may receive payment under fee-for-service arrangements at standard Medicaid rates.

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- Under risk-sharing arrangements, physicians are paid under a capitated or fee-for-service arrangement. The arrangement, however, contains provisions for additional bonus to the physicians or reimbursement from the physicians based upon cost and quality measures.

We work with physicians to help them operate efficiently by providing financial and utilization information, physician and patient educational programs and disease and medical management programs. Our programs are also designed to help the physicians coordinate care outside of their offices.

We believe our collaborative approach with physicians gives us a competitive advantage in entering new markets. Our physicians serve on local committees that assist us in implementing preventive care programs, managing costs and improving the overall quality of care delivered to our members, while also simplifying the administrative burdens on our providers. This approach has enabled us to strengthen our provider networks through improved physician recruitment and retention that, in turn, have helped to increase our membership base. The following are among the services we provide to support physicians:

- Customized Utilization Reports provide certain of our contracted physicians with information that enables them to run their practices more efficiently and focuses them on specific patient needs. For example, quarterly detail reports update physicians on their status within their risk pools. Equivalency reports provide physicians with financial comparisons of capitated versus fee-for-service arrangements.

- Case Management Support helps the physician coordinate specialty care and ancillary services for patients with complex conditions and direct members to appropriate community resources to address both their health and socio-economic needs.

- Web-based Claims and Eligibility Resources have been implemented to provide physicians with on-line access to perform claims and eligibility inquiries.

Our contracted physicians also benefit from several of the services offered to our members, including the MemberConnections, EPSDT case management and health management programs. For example, the MemberConnections staff facilitates doctor/patient relationships by connecting members with physicians, the EPSDT programs encourage routine checkups for children with their physicians and the health management programs assist physicians in managing their patients with chronic disease.

Where appropriate, our health plans contract with our specialty services organizations to provide services and programs such as behavioral health, life and health management, managed vision, telehealth services, pharmacy benefits management and specialty pharmacy. When necessary, we also contract with third-party providers on a negotiated fee arrangement for physical therapy, home healthcare, dental, diagnostic laboratory tests, x-ray examinations, transportation, ambulance services and durable medical equipment.

Quality Management

Our medical management programs focus on improving quality of care in areas that have the greatest impact on our members. We employ strategies, including health management and complex case management, that are adjusted for implementation in our individual markets by a system of physician committees chaired by local physician leaders. This process promotes physician participation and support, both critical factors in the success of any clinical quality improvement program.

We have implemented specialized information systems to support our medical quality management activities. Information is drawn from our data warehouse, clinical databases and our membership and claims processing system to identify opportunities to improve care and to track the outcomes of the interventions implemented to achieve those improvements. Some examples of these intervention programs include:

- appropriate leveling of care for neonatal intensive care unit hospital admissions, other inpatient hospital admissions, and observation admissions, in accordance with Interqual criteria
- tightening of our pre-authorization list and more stringent review of durable medical equipment and injectibles
- emergency department, or ED, program designed to collaboratively work with hospitals to steer non-emergency care away from the costly ED setting (through patient education, on-site alternative urgent care settings, etc.)

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- increase emphasis on case management and clinical rounding where case managers are nurses or social workers who are employed by the health plan to assist selected members with the coordination of healthcare services in order to meet a member's specific healthcare needs

- incorporation of disease management, which is a comprehensive, multidisciplinary, collaborative approach to chronic illnesses such as asthma and diabetes

- Start Smart For Your Baby, a prenatal case management program aimed at helping women with high-risk pregnancies deliver full-term, healthy infants

We provide reporting on a regular basis using our data warehouse. State and Health Employer Data and Information Set, or HEDIS, reporting constitutes the core of the information base that drives our clinical quality performance efforts. This reporting is monitored by Plan Quality Improvement Committees and our corporate medical management team.

In an effort to ensure the quality of our provider networks, we undertake to verify the credentials and background of our providers using standards that are supported by the National Committee for Quality Assurance, or NCQA.

It is our objective to provide access to the highest quality of care for our members. As a validation of that objective, we often pursue accreditation by independent organizations that have been established to promote healthcare quality. The NCQA Health Plan Accreditation and URAC Health Plan Accreditation programs provide unbiased, third party reviews to verify and publicly report results on specific quality care metrics. While we have achieved or are pursuing accreditation for all of our plans, accreditation is only one measure of our ability to provide access to quality care for our members. We currently have nine health plans and three specialty companies with NCQA accreditation.

SPECIALTY SERVICES

Our specialty services are a key component of our healthcare enterprise and complement our core Managed Care business. Specialty services diversify our revenue stream, provide higher quality health outcomes to our membership and others, and assist in controlling costs. Our specialty services are provided primarily through the following businesses:

- Behavioral Health. Cenpatico Behavioral Health, or Cenpatico, manages behavioral healthcare for members via a contracted network of providers. Cenpatico works with providers to determine the best services to help people overcome mental illness and lead productive lives. Our networks feature a full range of services and levels of care to help people with mental illness reach their recovery and wellness goals. In addition, we operate school-based programs in Arizona that focus on students with special needs and also provide speech and other therapy services.

- Correctional Services. Centurion, our joint venture subsidiary with MHM Services Inc., provides comprehensive healthcare services to individuals incarcerated in Massachusetts and Tennessee state correctional facilities. Beginning in January 2014, Centurion also began operating under a new contract with the Minnesota Department of Corrections.

- In-Home Health Services. U.S. Medical Management, our majority owned subsidiary acquired in January 2014, provides in-home health services for high acuity populations.

- Individual Insurance. Celtic Insurance Company, or Celtic, is a nationwide healthcare provider licensed in 49 states offering high-quality, affordable health insurance to individual customers and their families. Sold online and through independent insurance agents nationwide, Celtic's portfolio of major medical plans is designed to meet the diverse needs of the uninsured at all budget and benefit levels. Celtic also offers a standalone guaranteed-issue medical conversion program to self-funded employer groups, stop-loss and fully-insured group carriers, managed care plans, and HMO reinsurers.

- Life and Health Management. Nurtur specializes in implementing life and health management programs that encourage healthy behaviors, promote healthier workplaces, improve workforce and societal productivity and reduce healthcare costs. Health risk appraisals, biometric screenings, online and telephonic wellness programs, disease management and work-life/employee assistance services are areas of focus. Nurtur uses telephonic health and work/life balance coaching, in-home and online interaction and informatics processes to deliver effective clinical outcomes, enhanced patient-provider satisfaction and lower overall healthcare cost.

- Managed Vision. OptiCare Managed Vision, Inc., or OptiCare, administers routine and medical surgical eye care benefits via its own contracted national network of eye care providers. OptiCare clients include Medicaid, Medicare, and commercial health plans, as well as employer groups. OptiCare has been providing vision network services for over 25 years and offers a variety of plan designs to meet the individual needs of its clients and members.

- Telehealth Services. NurseWise LP provides a toll-free nurse triage line 24 hours per day, 7 days per week, 52 weeks per year. Our members call one number and reach bilingual customer service representatives and nursing staff who provide health education, triage advice and offer continuous access to health plan functions. Additionally, our representatives verify eligibility, confirm primary care provider assignments and provide benefit and network referral coordination for members and providers after business hours. Our staff can arrange for urgent pharmacy refills, transportation and qualified behavioral health professionals for crisis stabilization assessments.

- Pharmacy Benefits Management & Specialty Pharmacy. US Script, Inc., or US Script, offers progressive pharmacy benefits management services that are specifically designed to improve quality of care while containing costs. This is achieved through a lowest net cost strategy that helps optimize clients' pharmacy benefit. Services include claims processing, pharmacy network management, benefit design consultation, drug utilization review, formulary and rebate management, specialty and mail order pharmacy services, and patient and physician intervention.

In April 2013, we acquired AcariaHealth, a comprehensive specialty pharmacy company. With this transaction, we expanded our specialized pharmacy benefit services for complex diseases, including Hepatitis C, Hemophilia, Multiple Sclerosis, Rheumatoid Arthritis and Oncology.

- Care Management Software. Casenet, LLC, or Casenet, is a software provider of innovative care management solutions that automate the clinical, administrative and technical components of care management programs. During 2012, we acquired the remaining minority interest in Casenet and implemented this new software platform, which is available for sale to third parties and used by our health plans.

CORPORATE COMPLIANCE

Our Corporate Ethics and Compliance Program provides controls by which we assure that our values are reflected in everything we do, further enhance operations, improve access to quality care and safeguard against fraud and abuse.

The two primary standards by which corporate compliance programs in the healthcare industry are measured are the Federal Organizational Sentencing Guidelines and Compliance Program Guidance series issued by the Department of Health and Human Services' Office of the Inspector General, or OIG. Our program contains each of the seven elements suggested by the Sentencing Guidelines and the OIG guidance. These key components are:

- written standards of conduct
- designation of a corporate compliance officer and compliance committee
- effective training and education
- effective lines for reporting and communication
- enforcement of standards through disciplinary guidelines and actions
- internal monitoring and auditing
- prompt response to detected offenses and development of corrective action plans

The goal of the program is to build a culture of ethics and compliance, which is assessed periodically using a diagnostic survey to measure the integrity of the organization. Our internal Corporate Compliance intranet site, accessible to all employees, contains our Business Ethics and Conduct Policy (Code of Conduct), Compliance

Program description and various resources for employees to report concerns or ask questions. If needed, employees have access to the contact information for the members of our Board of Directors' Audit Committee to report concerns. Our Ethics and Compliance Helpline is a toll-free number and web-based reporting tool operated by a third party independent of the Company and allows employees or other persons to report suspected incidents of misconduct, fraud, abuse or other compliance violations. Furthermore, the Board of Directors reviews an ethics and compliance report on a quarterly basis.

COMPETITION

We continue to face varying and increasing levels of competition as we expand in our existing service areas or enter new markets. Federal regulations require at least two competitors in each service area. Healthcare reform may cause a number of commercial managed care organizations to decide to enter or exit the Medicaid market.

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In our business, our principal competitors for state contracts, members and providers consist of the following types of organizations:

- Medicaid Managed Care Organizations focus on providing healthcare services to Medicaid recipients. These organizations consist of national and regional organizations, as well as not-for-profits and smaller organizations that operate in one city or state and are owned by providers, primarily hospitals.

- National and Regional Commercial Managed Care Organizations have Medicaid members in addition to members in private commercial plans. Some of these organizations offer a range of specialty services including pharmacy benefits management, behavioral health management, health management, and nurse triage call support centers.

- Primary Care Case Management Programs are programs established by the states through contracts with primary care providers. Under these programs, physicians provide primary care services to Medicaid recipients, as well as limited medical management oversight.

We compete with other managed care organizations and specialty companies for state contracts. In order to grant a contract, state governments consider many factors. These factors include quality of care, financial requirements, an ability to deliver services and establish provider networks and infrastructure. In addition, our specialty companies also compete with other providers, such as disease management companies, individual health insurance companies, and pharmacy benefits managers for non-governmental contracts.

We also compete to enroll new members and retain existing members. People who wish to enroll in a managed healthcare plan or to change healthcare plans typically choose a plan based on the quality of care and services offered, ease of access to services, a specific provider being part of the network and the availability of supplemental benefits.

We also compete with other managed care organizations to enter into contracts with physicians, physician groups and other providers. We believe the factors that providers consider in deciding whether to contract with us include existing and potential member volume, reimbursement rates, medical management programs, speed of reimbursement and administrative service capabilities. See “Risk Factors - Competition may limit our ability to increase penetration of the markets that we serve.”

REGULATION

Our operations are regulated at both state and federal levels. Government regulation of the provision of healthcare products and services is a changing area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules also may occur periodically.

Our regulated subsidiaries are licensed to operate as health maintenance organizations, third party administrators, utilization review and/or insurance companies in their respective states. In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health and/or human services departments that oversee the activities of managed care organizations providing or arranging to provide services to Medicaid, Medicare and Health Insurance Marketplace enrollees.

The process for obtaining authorization to operate as a managed care organization is complex and requires us to demonstrate to the regulators the adequacy of the health plan's organizational structure, financial resources, utilization review, quality assurance programs, complaint procedures, provider network and procedures for covering emergency medical conditions. Under both state managed care organization statutes and insurance laws, our health plan subsidiaries, as well as our applicable specialty companies, must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements. Insurance regulations may also require prior state approval of acquisitions of other managed care organization businesses and the payment of dividends, as well as notice for loans or the transfer of funds. Our subsidiaries are also subject to periodic state and federal reporting requirements. In addition, each health plan and individual health insurance provider must meet criteria to secure the approval of state regulatory authorities before implementing operational changes, including the development of new product offerings and, in some states, the expansion of service areas.

States have adopted a number of regulations that may affect our business and results of operations. These regulations in certain states include:

- premium taxes or similar assessments
- stringent prompt payment laws

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- disclosure requirements regarding provider fee schedules and coding procedures
- programs to monitor and supervise the activities and financial solvency of provider groups

We are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our insurance company and HMO subsidiaries are domiciled. These acts contain certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. These holding company laws and regulations generally require insurance companies and HMOs within an insurance holding company system to register with the insurance department of each state where they are domiciled and to file with those states' insurance departments reports describing capital structure, ownership, financial condition, intercompany transactions and general business operations. In addition, depending on the size and nature of the transaction, there are various notice and reporting requirements that generally apply to transactions between insurance companies and HMOs and their affiliates within an insurance holding company structure. Some insurance holding company laws and regulations require prior regulatory approval or, in certain circumstances, prior notice of certain material intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other provisions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends.

Additionally, the holding company acts of the states in which our subsidiaries are domiciled restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval or an exemption, no person may acquire any voting security of an insurance holding company, which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would “control” the insurance holding company. “Control” is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a company and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of a company.

Our mail order pharmacies must be licensed to do business as pharmacies in the states in which they are located. Our mail order pharmacies must also register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities to dispense controlled substances. In many of the states where our mail order pharmacies deliver pharmaceuticals, there are laws and regulations that require out-of-state mail order pharmacies to register with that state’s board of pharmacy or similar regulatory body. These states generally permit the pharmacy to follow the laws of the state in which the mail order pharmacy is located, although some states require that we also comply with certain laws in that state.

State Contracts

In addition to being a licensed insurance company or health maintenance organization, in order to be a Medicaid managed care organization in each of the states in which we operate, we must operate under a contract with the state's Medicaid agency. States generally use either a formal proposal process, reviewing a number of bidders, or award individual contracts to qualified applicants that apply for entry to the program. We receive monthly payments based on specified capitation rates determined on an actuarial basis. These rates differ by membership category and by state depending on the specific benefits and policies adopted by each state.

Our state contracts and the regulatory provisions applicable to us generally set forth the requirements for operating in the Medicaid sector, including provisions relating to:

- eligibility, enrollment and dis-enrollment processes
- covered services
- eligible providers
- subcontractors

- record-keeping and record retention
- periodic financial and informational reporting
- quality assurance
- accreditation

- health education and wellness and prevention programs
- timeliness of claims payment
- financial standards
- safeguarding of member information
- fraud and abuse detection and reporting
- grievance procedures
- organization and administrative systems

A health plan or individual health insurance provider's compliance with these requirements is subject to monitoring by state regulators and by CMS. A health plan is also subject to periodic comprehensive quality assurance evaluations by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan. A health plan or individual health insurance provider must also submit reports to various regulatory agencies, including quarterly and annual statutory financial statements and utilization reports.

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The table below sets forth the terms of our contracts and provides details regarding related renewal or extension and termination provisions. The contracts are subject to termination for cause, an event of default or lack of funding.

Contract	Expiration Date	Renewal or Extension
Arizona - Behavioral Health	June 30, 2014	Renewable for one additional one-year term.
Arizona - LTC	September 30, 2014	May be extended for up to two additional one-year terms.
Arizona - Special Needs Plan (Medicare)	December 31, 2014	Renewable annually for successive 12-month periods.
California - Medicaid, ABD & CHIP	October 31, 2018	Renewable up to three additional one-year terms.
Florida - CHIP	September 30, 2014	May be extended for up to two additional one-year terms.
Florida - Foster Care	(1)	(1)
Florida - LTC	August 31, 2018	Renewable through the state's recertification process.
Florida - Medicaid & ABD [(2)]	August 31, 2015	Renewable through the state's recertification process.
Florida - Special Needs Plan (Medicare)	December 31, 2014	Renewable annually for successive 12-month periods.
Georgia - Medicaid & CHIP	June 30, 2014	Renewable for two additional one-year terms.
Georgia - Special Needs Plan (Medicare)	December 31, 2014	Renewable annually for successive 12-month periods.
Illinois - ABD & LTC	April 30, 2016	May be extended for up to five additional years.
Illinois - Duals	December 31, 2015	Renewable for two additional one-year terms.
Indiana - Medicaid, CHIP & Hybrid (Healthy Indiana Plan)	December 31, 2014	Renewable for two additional one-year terms.
Kansas - Medicaid, ABD, CHIP, LTC & Foster Care	December 31, 2015	Renewable for two additional one-year terms.
Louisiana - Medicaid, CHIP, ABD & Foster Care	January 31, 2015	Renewable for an additional two-year period through the state's recertification process.
Massachusetts - Correctional Services	June 30, 2018	Renewable for two additional one-year terms.
Massachusetts - Medicaid	September 30, 2015	May be extended for five additional one-year terms.
Massachusetts - Hybrid (Commonwealth Care)	March 31, 2014	Program ending March 31, 2014.
Minnesota - Correctional Services	June 30, 2016	May be extended for up to two and a half additional years.
Mississippi - Medicaid, ABD & Foster Care	June 30, 2014	Renewable through the state's reprocurement process. [(3)]

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Missouri - Medicaid, CHIP & Foster Care	June 30, 2014	Renewable for one additional one-year term.
New Hampshire - Medicaid, CHIP, Foster Care & ABD	June 30, 2015	Renewable for one additional two-year term.
Ohio - Duals	(1)	(1)
Ohio - Medicaid, CHIP & ABD	June 30, 2014	Renewable annually for successive 12-month periods.
Ohio - Special Needs Plan (Medicare)	December 31, 2014	Renewable annually for successive 12-month periods.
South Carolina - Medicaid, CHIP & ABD	June 30, 2014	Renewable through the state's recertification process.
South Carolina - Duals	(1)	(1)
Tennessee - Correctional Services	August 31, 2016	Renewable through the state's reprocurement process.
Texas - ABD Dallas Expansion	August 31, 2015	May be extended for up to three additional years.
Texas - ABD MRSA	August 31, 2017	May be extended for up to five additional years.
Texas - CHIP Rural Service Area	August 31, 2015	May be extended for up to three additional years.
Texas - Foster Care	February 22, 2015	Renewable through the state's reprocurement process.
Texas - Hybrid (Healthy Texas)	August 31, 2015	(4)
Texas - Medicaid, CHIP &ABD	August 31, 2015	May be extended for up to four and a half additional years.
Texas - Special Needs Plan (Medicare)	December 31, 2014	Renewable annually for successive 12-month periods.
Washington - Medicaid, CHIP, Foster Care & ABD	December 31, 2014	Renewable through the state's recertification process.
Wisconsin - Medicaid, CHIP & ABD	December 31, 2015	Renewable through the state's recertification process every two years.
Wisconsin - Network Health Plan Subcontract	December 31, 2015	(5)
Wisconsin - Special Needs Plan (Medicare)	December 31, 2014	Renewable annually for successive 12-month periods.

(1) The Company has received notice of intent to award a contract, however a final contract has not yet been executed.

(2) The current contract expires in August 2015. In September 2013, the Florida Agency for Health Care Administration provided notice of intent to award a contract to our Florida subsidiary, Sunshine Health, in 9 of 11 regions of the Managed Medical Assistance (MMA) program. The MMA program includes TANF recipients as well as ABD and dual-eligible members. The award is subject to challenge and contract readiness periods, with enrollment expected to begin in the second quarter of 2014 and continue through October 2014.

(3) The current contract expires June 30, 2014. In February 2014, the State of Mississippi Department of Medicaid provided notice of intent to award a contract to our Mississippi subsidiary, Magnolia Health, to continue serving Medicaid, ABD and Foster Care members effective July 1, 2014 for a three-year period, renewable for up to two additional years.

(4) The Texas Health and Human Services Commission (HHSC) has communicated that the Healthy Texas program is expected to end in December 2014.

(5) The Company and NHP are currently in negotiation regarding any future extensions.

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Marketplace Contracts

Beginning in 2014, we began operating under federally facilitated Marketplace contracts with CMS in seven states: Arkansas, Florida, Georgia, Indiana, Mississippi, Ohio and Texas. These contracts expire annually and are renewable upon mutual consent.

In 2014, we also began operating under two state based Marketplaces in Massachusetts and Washington that expire annually. The Massachusetts contract may be extended for up to two additional one-year terms. The Washington contract is renewable annually through the state's recertification process.

In addition, we began operating under a contract with the Arkansas division of Medical Services and the Arkansas Insurance Department to participate in the Medicaid expansion model that Arkansas has adopted (referred to as the "private option") in January 2014. This contract expires December 31, 2014 and may be extended for subsequent and consecutive one year terms.

HIPAA Omnibus Rule and HITECH

In 1996, Congress enacted the Health Insurance Portability and Accountability Act, or HIPAA. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act. HIPAA is designed to improve the portability and continuity of health insurance coverage, simplify the administration of health insurance through standard transactions and ensure the privacy and security of individual health information. Among the main requirements of HIPAA are the Administrative Simplification provisions which include: standards for processing health insurance claims and related transactions (Transactions Standards); requirements for protecting the privacy and limiting the use and disclosure of medical records and other personal health information (Privacy Rule); and standards and specifications for safeguarding personal health information which is maintained, stored or transmitted in electronic format (Security Rule). The Health Information Technology for Economic and Clinical Health (HITECH) Act amended certain provisions of HIPAA and introduced new data security obligations for covered entities and their business associates. HITECH also mandated individual notifications in instances of a data breach, provided enhanced penalties for HIPAA violations, and granted enforcement authority to states' Attorneys General in addition to the HHS Office of Civil Rights. The HIPAA Omnibus Rule is based on the changes under the HITECH Acts and the Genetic Information Nondiscrimination Act of 2008 (GINA) which clarifies that genetic information is protected under the HIPAA Privacy Rule and prohibits most health plans from using or disclosing genetic information for underwriting purposes. This Omnibus rule enhances the privacy protections and strengthens the government's ability to enforce the law. The preemption provisions of HIPAA provide that the federal standards will not preempt state laws that are more stringent than the related federal requirements.

The Privacy and Security Rules and HITECH/Omnibus enhancements establish requirements to protect the privacy of medical records and safeguard personal health information maintained and used by healthcare providers, health plans, healthcare clearinghouses, and their business associates.

The Security Rule requires healthcare providers, health plans, healthcare clearinghouses, and their business associates to implement administrative, physical and technical safeguards to ensure the privacy and confidentiality of health information when it is electronically stored, maintained or transmitted. The HITECH Act and Omnibus Rule established a federal requirement for notification when the security of protected health information is breached. In addition, there are state laws that have been adopted to provide for, among other things, private rights of action for breaches of data security and mandatory notification to persons whose identifiable information is obtained without authorization.

The requirements of the Transactions Standards apply to certain healthcare related transactions conducted using "electronic media." Since "electronic media" is defined broadly to include "transmissions that are physically moved from one location to another using magnetic tape, disk or compact disk media," many communications are considered to be electronically transmitted. Under HIPAA, health plans are required to have the capacity to accept and send all covered transactions in a standardized electronic format. Penalties can be imposed for failure to comply with these requirements. The transaction standards have been modified to version 5010 to prepare for the implementation of the ICD-10 coding system. We are planning for an expected transition to ICD-10 in October 2014.

We have implemented processes, policies and procedures to comply with HIPAA, HITECH and the Omnibus Rule, including administrative, technical and physical safeguards to prevent against electronic data breach. We provide education and training for employees specifically designed to help prevent any unauthorized use or access to health information and enhance the reporting of suspected breaches. In addition, our corporate privacy officer and health plan privacy officials handle privacy complaints and serve as resources to employees to address questions or concerns they may have.

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Other Fraud and Abuse Laws

Investigating and prosecuting healthcare fraud and abuse continues to be a top priority for state and federal law enforcement entities. The focus of these efforts has been directed at participants in public government healthcare programs such as Medicare and Medicaid. The laws and regulations relating to fraud and abuse and the contractual requirements applicable to health plans participating in these programs are complex and regularly changing and compliance with them may require substantial resources. We are constantly looking for ways to improve our waste, fraud and abuse detection methods. While we have both prospective and retrospective processes to identify abusive patterns and fraudulent billing, we continue to increase our capabilities to proactively detect inappropriate billing prior to payment.

EMPLOYEES

As of December 31, 2013, we had approximately 8,800 employees. None of our employees are represented by a union. We believe our relationships with our employees are positive.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following table sets forth information regarding our executive officers, including their ages, at February 8, 2014:

Name	Age	Position
Michael F. Neidorff	71	Chairman, President and Chief Executive Officer
K. Rone Baldwin	55	Executive Vice President, Insurance Group Business Unit
Carol E. Goldman	56	Executive Vice President and Chief Administrative Officer
Jason M. Harrold	44	Executive Vice President, Specialty Company Business Unit
Robert T. Hitchcock	47	Executive Vice President, Health Plan Business Unit
Jesse N. Hunter	38	Executive Vice President, Chief Business Development Officer
Donald G. Imholz	61	Executive Vice President, Operations and Chief Information Officer
Edmund E. Kroll	54	Senior Vice President, Finance and Investor Relations
C. David Minifie	43	Executive Vice President, Business Integration & Chief Marketing Officer
William N. Scheffel	60	Executive Vice President, Chief Financial Officer and Treasurer
Jeffrey A. Schwaneke	38	Senior Vice President, Corporate Controller and Chief Accounting Officer
Keith H. Williamson	61	Executive Vice President, General Counsel and Secretary

Michael F. Neidorff. Mr. Neidorff has served as our Chairman and Chief Executive Officer since May 2004. From May 1996 to May 2004, Mr. Neidorff served as President, Chief Executive Officer and as a member of our Board of Directors. Mr. Neidorff also serves as a director of Brown Shoe Company, Inc., a publicly-traded footwear company with global operations.

K. Rone Baldwin. Mr. Baldwin has served as our Executive Vice President, Insurance Group Business Unit since December 2012. Prior to joining Centene, he served as Executive Vice President and Business Leader of Group Insurance Business, which included both group health and ancillary product lines, for Guardian Life Insurance Company, which he joined in 2006.

Carol E. Goldman. Ms. Goldman has served as Executive Vice President and Chief Administrative Officer since June 2007. Prior to this position, Ms. Goldman has held various positions of increasing responsibility since joining Centene in 2001.

Jason M. Harrold. Mr. Harrold has served as our Executive Vice President, Specialty Company Business Unit since April 2012. From August 2009 to April 2012, he served as our Senior Vice President, Specialty Business Unit. He served as President of OptiCare from July 2000 to August 2009.

Robert T. Hitchcock. Mr. Hitchcock has served as our Executive Vice President, Health Plan Business Unit, since October 2012. From March 1997 to October 2012, Mr. Hitchcock held various positions of increasing responsibility at Humana including Divisional Vice President, Western Division Medicare Operations.

Jesse N. Hunter. Mr. Hunter has served as our Executive Vice President, Chief Business Development Officer since December 2012. From February 2012 to December 2012, he served as our Executive Vice President, Operations. He

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previously served as our Executive Vice President, Corporate Development from April 2008 to February 2012. He served as our Senior Vice President, Corporate Development from April 2007 to April 2008.

Donald G. Imholz. Mr. Imholz has served as our Executive Vice President, Operations and Chief Information Officer since December 2009. Mr. Imholz served as our Senior Vice President and Chief Information Officer from September 2008 to December 2009.

Edmund E. Kroll. Mr. Kroll has served as our Senior Vice President, Finance and Investor Relations since May 2007.

C. David Minifie. Mr. Minifie has served as our Executive Vice President, Business Integration & Chief Marketing Officer since December 2012. He previously served as our Vice President, Chief Marketing Officer from April 2012 to December 2012. From 1999 to April 2012, Mr. Minifie held various positions of increasing responsibility at Procter & Gamble including Global Eukanuba Associate Marketing Director.

William N. Scheffel. Mr. Scheffel has served as our Executive Vice President, Chief Financial Officer and Treasurer since May 2009. He served as our Executive Vice President, Specialty Business Unit from June 2007 to May 2009.

Jeffrey A. Schwaneke. Mr. Schwaneke has served as our Senior Vice President, Corporate Controller since December 2011 and our Chief Accounting Officer since September 2008. He served as our Vice President, Corporate Controller from July 2008 to December 2011. He previously served as Vice President, Controller and Chief Accounting Officer at Novelis Inc. from October 2007 to July 2008.

Keith H. Williamson. Mr. Williamson has served as our Executive Vice President, General Counsel and Secretary since November 2012. He served as Senior Vice President and General Counsel from November 2006 to November 2012. Mr. Williamson also serves as a director of PPL Corporation, a publicly-traded utility holding company.

Available Information

We are subject to the reporting and information requirements of the Securities Exchange Act of 1934, as amended (Exchange Act) and, as a result, we file periodic reports and other information with the Securities and Exchange Commission, or SEC. We make these filings available on our website free of charge, the URL of which is http://www.centene.com, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. The SEC maintains a website (http://www.sec.gov) that contains our annual, quarterly and current reports and other information we file electronically with the SEC. You can read and copy any materials we file with the SEC at the SEC's Public Reference Room at 100 F Street, N.E., Room 1850, Washington, D.C. 20549. You may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. Information on our website does not constitute part of this Annual Report on Form 10-K.

ITEM 1A. Risk Factors.

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

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

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

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, CHIP, LTC, ABD, Foster Care and Health Insurance Marketplace premiums. The base premium rate paid for each program differs, depending on a combination of factors such as defined upper payment limits, a member’s health status, age, gender, county or region and benefit mix. Since Medicaid was created in 1965, the federal government and the states have shared the costs, with the federal share currently averaging around 57%.

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Future levels of funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Governments periodically consider reducing or reallocating the amount of money they spend for Medicaid, Medicare, CHIP, LTC, ABD and Foster Care. Adverse economic conditions may continue to put pressures on state budgets as tax and other state revenues decrease while the population that is eligible to participate in these programs increases, creating more need for funding. We anticipate this will require government agencies to find funding alternatives, which may result in reductions in funding for programs, contraction of covered benefits, and limited or no premium rate increases or premium rate decreases. A reduction (or less than expected increase), a protracted delay, or a change in allocation methodology in government funding for these programs, as well as termination of the contract for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows.

Additionally, changes in these programs could reduce the number of persons enrolled in or eligible for these programs or increase our administrative or healthcare costs under these programs. Recent legislation generally requires that eligibility levels be maintained, but this could cause states to reduce reimbursement or reduce benefits in order for states to afford to maintain eligibility levels. If any state in which we operate were to decrease premiums paid to us or pay us less than the amount necessary to keep pace with our cost trends, it could have a material adverse effect on our results of operations, financial position and cash flows.

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

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

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

Our medical expense includes claims reported but not paid, estimates for claims incurred but not reported, and estimates for the costs necessary to process unpaid claims at the end of each period. Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information as well as inpatient acuity information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified. However, we still cannot be sure that our medical claims liability estimate is adequate or that adjustments to the estimate will not unfavorably impact our results of operations.

Additionally, when we commence operations in a new state, region or product, we have limited information with which to estimate our medical claims liability. For a period of time after the inception of the new business, we base our estimates on state-provided historical actuarial data and limited actual incurred and received claims and inpatient acuity information. The addition of new categories of individuals who are eligible under new legislation may pose the same difficulty in estimating our medical claims liability. Similarly, we may face difficulty in estimating our medical claims liability beginning in January 2014 when we begin providing coverage for the first time under the newly created Health Insurance Marketplaces.

From time to time in the past, our actual results have varied from our estimates, particularly in times of significant changes in the number of our members. If it is determined that our estimates are significantly different than actual results, our results of operations and financial position could be adversely affected. In addition, if there is a significant delay in our receipt of premiums, our business operations, cash flows, or earnings could be negatively impacted.

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

In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act, collectively referred to as the Affordable Care Act (ACA), were enacted. While the constitutionality of the ACA was generally upheld by the Supreme Court in 2012, the Court determined that states could not be required to expand Medicaid and risk losing all federal money for their existing Medicaid programs.

Under the ACA, Medicaid coverage was expanded to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to each states' election. The federal government will pay the entire costs for Medicaid coverage for newly eligible beneficiaries for 3 years (2014 through 2016). Beginning in 2017, the federal share begins to decline to 90% by 2020 and subsequent years. To date, 25 states have expanded Medicaid eligibility, and the remaining states are involved in a variety of legislative proposals. The ACA also extended CHIP through September 30, 2019.

The ACA required the establishment of Health Insurance Marketplaces for individuals and small employers to purchase health insurance coverage commencing in January 2014. Open enrollment began on October 1, 2013 and continues until March 31, 2014. The ACA required insurers participating on the Health Insurance Marketplaces to offer a minimum level of benefits and included guidelines on setting premium rates and coverage limitations.

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

The U.S. Department of Health and Human Services (HHS) has stated that it will consider a limited number of premium assistance demonstration proposals from States that want to privatize Medicaid expansion. States must provide a choice between at least two qualified health plans and offer very similar benefits as those available in the newly created Health Insurance Marketplaces. Arkansas became the first state to obtain federal approval to use Medicaid funding to purchase private insurance for low-income residents and we began operations under the program beginning January 1, 2014.

The ACA imposes an annual insurance industry assessment of $8 billion starting in 2014, with increasing annual amounts thereafter. Such assessments are not deductible for income tax purposes. The fee will be allocated based on health insurers' premium revenues in the previous year. Each health insurer's fee is calculated by multiplying its market share by the annual fee. Market share is based on commercial, Medicare, and Medicaid premium revenue. Not-for-profit insurers may have a competitive advantage since they are exempt from paying the fee if they receive at least 80% of their premium revenue from Medicare, Medicaid, and CHIP, and other not-for-profit insurers are allowed to exclude 50% of their premium revenue from the fee calculation. If this federal premium assessment is imposed as enacted, and if we are not reimbursed by the states for the cost of the federal premium assessment (including the associated tax impact), or if we are unable to otherwise adjust our business model to address this new assessment, our results of operations, financial position and cash flows may be materially adversely affected.

There are numerous steps required to implement the legislation, including the promulgation of a substantial number of new and potentially more onerous federal regulations. Further, various health insurance reform proposals are also emerging at the state level. Because of the unsettled nature of these reforms and numerous steps required to implement them, we cannot predict what additional health insurance requirements will be implemented at the federal or state level, or the effect that any future legislation or regulation will have on our business or our growth opportunities. Although we believe the legislation may provide us with significant opportunities to grow our business, the enacted reforms, as well as future regulations and legislative changes, may in fact have a material adverse effect on our results of operations, financial position or liquidity. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of healthcare reform, or do not do so as effectively as our competitors, our results of operations may be materially adversely affected.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could force us to change how we operate and could harm our business.

Our business is extensively regulated by the states in which we operate and by the federal government. In addition, the managed care industry has received negative publicity that has led to increased legislation, regulation, review of industry

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practices and private litigation in the commercial sector. In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health and/or human services departments that oversee the activities of managed care organizations providing or arranging to provide services to Medicaid, Medicare and Health Insurance Marketplace enrollees. For example, our health plan subsidiaries, as well as our applicable specialty companies, must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements.

The frequent enactment of, changes to, or interpretations of laws and regulations could, among other things: force us to restructure our relationships with providers within our network; require us to implement additional or different programs and systems; restrict revenue and enrollment growth; increase our healthcare and administrative costs; impose additional capital and surplus requirements; and increase or change our liability to members in the event of malpractice by our contracted providers. In addition, changes in political party or administrations at the federal or state level may change the attitude towards healthcare programs.

Our contracts with states may require us to maintain a minimum health benefits ratio or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to rebate premium back to the state in the event profits exceed established levels or HBR does not meet the minimum requirement. Other states may require us to meet certain performance and quality metrics in order to maintain our contract or receive additional or full contractual revenue.

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

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

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

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

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

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

We are also subject to various reviews, audits and investigations to verify our compliance with the terms of our contracts with various governmental agencies and applicable laws and regulations. Any adverse review, audit or investigation could result in: cancellation of our contracts; refunding of amounts we have been paid pursuant to our contracts; imposition of fines, penalties and other sanctions on us; loss of our right to participate in various programs; increased difficulty in selling our products and services; or loss of one or more of our licenses.

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

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

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

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

We maintain a significant investment portfolio of cash equivalents and short-term and long-term investments in a variety of securities, which are subject to general credit, liquidity, market and interest rate risks and will decline in value if interest rates increase or one of the issuers’ credit ratings is reduced. As a result, we may experience a reduction in value or loss of liquidity of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition.

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

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

In connection with start-up operations, we may incur significant expenses prior to commencement of operations and the receipt of revenue. For example, in order to obtain a certificate of authority in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to administer a state contract and process claims. We may experience delays in operational start dates. As a result of these factors, start-up operations may decrease our profitability. In the event we pursue any opportunity to diversify our business internationally, we would become subject to additional risks, including, but not limited to, political risk, an unfamiliar regulatory regime, currency exchange risk and exchange controls, cultural and language differences, foreign tax issues, and different labor laws and practices.

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

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

We are seeking to diversify our business lines into areas that complement our government sponsored health plan business in order to grow our revenue stream and balance our dependence on risk reimbursement. In order to diversify our business, we must succeed in selling the services of our specialty subsidiaries not only to our managed care plans, but to programs operated by third-parties. Some of these third-party programs may compete with us in some markets, and they therefore may be

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unwilling to purchase specialty services from us. In any event, the offering of these services will require marketing activities that differ significantly from the manner in which we seek to increase revenues from our government sponsored programs. Our ineffectiveness in marketing specialty services to third-parties may impair our ability to execute our business strategy.

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

The securities and credit markets have been experiencing extreme volatility and disruption over the past several years. The availability of credit, from virtually all types of lenders, has at times been restricted. In the event we need access to additional capital to pay our operating expenses, fund subsidiary surplus requirements, make payments on or refinance our indebtedness, pay capital expenditures, or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant, particularly if we are unable to access our existing credit facility.

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

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

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

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

Operations in a limited number of states have accounted for most of our premium revenues to date. If we were unable to continue to operate in any of our current states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on legislative or other governmental or regulatory actions and decisions, economic conditions and similar factors in those states. For example, states we currently serve may bid out their Medicaid program through a request for proposal process. Our inability to continue to operate in any of the states in which we operate could harm our business.

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

We compete for members principally on the basis of size and quality of provider networks, benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state Medicaid programs that reimburse providers as care is provided. In addition, the impact of healthcare reform legislation and potential growth in our segment may attract new competitors.

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

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

Our profitability depends, in large part, upon our ability to contract at competitive prices with hospitals, physicians and other healthcare providers. Our provider arrangements with our primary care physicians, specialists and hospitals generally may be canceled by either party without cause upon 90 to 120 days prior written notice. We cannot provide any assurance that we will be able to continue to renew our existing contracts or enter into new contracts on a timely basis or under favorable terms enabling us to service our members profitably. Healthcare providers with whom we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

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

From time to time providers assert or threaten to assert claims seeking to terminate non-cancelable agreements due to alleged actions or inactions by us. In addition, we are aware that other managed care organizations have been subject to class action suits by physicians with respect to claim payment procedures, and we may be subject to similar suits. Regardless of whether any suits brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively. If we are unable to retain our current provider contract terms or enter into new provider contracts timely or on favorable terms, our profitability may be harmed.

We may be unable to attract and retain key personnel.

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

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

Our operations depend significantly on effective information systems. The information gathered and processed by our information systems assists us in, among other things, monitoring utilization and other cost factors, processing provider claims, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status and other information. Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs and regulatory requirements. We regularly upgrade and expand our information systems' capabilities. If we experience difficulties with the transition to or from information systems or are unable to properly maintain or expand our information systems, we could suffer, among other things, operational disruptions, loss of existing members and difficulty in attracting new members, regulatory problems and increases in administrative expenses. In addition, our ability to integrate and manage our information systems may be impaired as the result of events outside our control, including acts of nature, such as earthquakes or fires, or acts of terrorists.

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

We are a defendant from time to time in lawsuits and regulatory actions relating to our business, including, without limitation, medical malpractice claims. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and financial position, results of operations or cash flows. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and time consuming and require significant attention from our management, and could therefore harm our business and financial position, results of operations or cash flows.

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

We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. Changes in business strategy, government regulations or economic or market conditions have resulted and may result in impairments of our goodwill and other intangible assets at any time in the future. Our judgments regarding the existence of impairment indicators are based on, among other things, legal factors, market conditions, and operational performance. For example, the non-renewal of our health plan contracts with the state in which they operate may be an indicator of impairment. If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill and other intangible assets, such revision could result in a non-cash impairment charge that could have a material impact on our results of operations in the period in which the impairment occurs.

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

As part of our normal operations, we collect, process and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act, which require us to protect the privacy of medical records and safeguard personal health information we maintain and use. Despite our best attempts to maintain adherence to information security best practices as well as compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to security breaches, acts of vandalism or theft, malware, misplaced or lost data including paper or electronic media, programming and/or human errors or other similar events. In the past, we have had data breaches resulting in disclosure of confidential or protected health information that have not resulted in any material financial loss or penalty to date. However, future data breaches could require us to expend significant resources to remediate any damage, interrupt our operations and damage our reputation, subject us to state or federal agency review and could also result in enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, reputation and results of operations, financial position and cash flows.

Many of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities.

HIPAA broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA created civil penalties for, among other things, billing for medically unnecessary goods or services. HIPAA established new enforcement mechanisms to combat fraud and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of protected health information. The HITECH Act expanded the scope of these provisions by mandating individual notification in instances of breaches of protected health information, providing enhanced penalties for HIPAA violations, and granting enforcement authority to states' Attorneys General in addition to the HHS Office of Civil Rights. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules. In addition, HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities. Although we are not aware of HHS plans to audit any of our covered entities, an audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Under HIPAA, health plans are required to have the capacity to accept and send all covered transactions in a standardized electronic format. Penalties can be imposed for failure to comply with these requirements. The transaction standards have been modified to version 5010 to prepare for the implementation of the ICD-10 coding system. While we have prepared for the transition to ICD-10 in October 2014, if unforeseen circumstances arise, it is possible that we could be exposed to investigations and allegations of noncompliance. In addition, if some providers continue to use ICD-9 codes on claims after October 1, 2014, we may have to reject such claims, which may lead to claim resubmissions, increased call volume and provider and customer dissatisfaction. Further, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, which could result in higher costs and reimbursement levels, or lost revenues under risk adjustment. During the transition to ICD-10, certain claims processing and payment information we have historically used to establish our reserves may not be reliable or available in a timely manner. As a result, implementation of ICD 10 may have a material adverse effect on our results of operations, financial position and cash flows.

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

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

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

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

We own our corporate office headquarters buildings and land located in St. Louis, Missouri. We generally lease space in the states where our health plans, specialty companies and claims processing facilities operate. We are required by various insurance and regulatory authorities to have offices in the service areas where we provide benefits. We believe our current facilities are adequate to meet our operational needs for the foreseeable future.

Item 3. Legal Proceedings.

In October 2012, the Company notified the Kentucky Cabinet for Health and Family Services (Cabinet) that it was exercising a contractual right that it believes allows the Company to terminate its Medicaid managed care contract with the Commonwealth of Kentucky (Commonwealth) effective July 5, 2013. The Company also filed a lawsuit in Franklin Circuit Court against the Commonwealth seeking a declaration of the Company's right to terminate the contract on July 5, 2013. In April 2013, the Commonwealth answered that lawsuit and filed counterclaims against the Company seeking declaratory relief and damages. In May 2013, the Franklin Circuit Court ruled that Kentucky Spirit does not have a contractual right to terminate the contract early. Kentucky Spirit has appealed that ruling to the Kentucky Court of Appeals.

The Company also filed a formal dispute with the Cabinet for damages incurred under the contract, which was later appealed to and denied by the Finance and Administration Cabinet. In response, the Company filed a lawsuit in April 2013, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches. This lawsuit was subsequently consolidated with the original lawsuit for declaratory relief and continues to proceed.

Kentucky Spirit's efforts to resolve issues with the Commonwealth were unsuccessful and on July 5, 2013, Kentucky Spirit proceeded with its previously announced exit. The Commonwealth has alleged that Kentucky Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25.0 million performance bond. Any claim for damages by the Commonwealth may include the costs of transition and the additional costs to the Commonwealth to cover Kentucky Spirit's former members through July 5, 2014. Kentucky Spirit is pursuing its litigation claims for damages against the Commonwealth and will vigorously defend against any allegations that it has breached the contract.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If the Company prevails on its claims, Kentucky Spirit would be entitled to damages under its lawsuit. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. The Company is unable to estimate the ultimate outcome resulting from the Kentucky

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litigation. As a result, the Company has not recorded any receivable or any liability for potential damages under the contract as of December 31, 2013. While uncertain, the ultimate resolution of the pending litigation could have a material effect on the financial position, cash flow or results of operations of the Company in the period it is resolved or becomes known.

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

Item 4. Mine Safety Disclosures

Not applicable.

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PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market for Common Stock; Dividends

Our common stock has been traded and quoted on the New York Stock Exchange under the symbol “CNC” since October 16, 2003. The high and low prices, as reported by the NYSE, are set forth below for the periods indicated.

	2014 Stock Price (through February 12, 2014)		2013 Stock Price		2012 Stock Price	
	High	Low	High	Low	High	Low
First Quarter	$63.09	$56.88	$48.55	$40.57	$50.36	$38.97
Second Quarter			52.74	42.14	50.98	24.26
Third Quarter			65.04	52.82	42.46	28.86
Fourth Quarter			67.84	54.12	46.44	34.73

As of February 14, 2014, there were 56 holders of record of our common stock.

We have never declared any cash dividends on our capital stock and currently anticipate that we will retain any future earnings for the development, operation and expansion of our business.

Issuer Purchases of Equity Securities

On October 26, 2009, the Company's Board of Directors extended the Company's stock repurchase program. The program authorizes the repurchase of up to 4,000,000 shares of the Company's common stock from time to time on the open market or through privately negotiated transactions. We have 1,667,724 available shares remaining under the program for repurchases as of December 31, 2013. No duration has been placed on the repurchase program. The Company reserves the right to discontinue the repurchase program at any time. During the year ended December 31, 2013, we did not repurchase any shares through this publicly announced program.

Issuer Purchases of Equity Securities
Fourth Quarter 2013

Period	Total Number of Shares Purchased[1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs[2]
October 1 – October 31, 2013	9,311	$62.37	—	1,667,724
November 1 – November 30, 2013	5,363	57.82	—	1,667,724
December 1 – December 31, 2013	234,055	56.44	—	1,667,724
Total	248,729	$56.69	—	1,667,724

(1) Shares acquired represent shares relinquished to the Company by certain employees for payment of taxes or option cost upon vesting of restricted stock units or option exercise.
(2) Our Board of Directors adopted a stock repurchase program which allows for repurchases of up to a remaining amount of 1,667,724 shares. No duration has been placed on the repurchase program.

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Stock Performance Graph

The graph below compares the cumulative total stockholder return on our common stock for the period from December 31, 2008 to December 31, 2013 with the cumulative total return of the New York Stock Exchange Composite Index and the Standard & Poor's Supercomposite Managed Healthcare Index over the same period. The graph assumes an investment of $100 on December 31, 2008 in our common stock (at the last reported sale price on such day), the New York Stock Exchange Composite Index and the Standard & Poor's Supercomposite Managed Healthcare Index and assumes the reinvestment of any dividends. In prior years, the Company used the Morgan Stanley Healthcare Payor Index, which was discontinued in October 2013.

	December 31,					
	2008	2009	2010	2011	2012	2013
Centene Corporation	$100.00	$107.41	$128.56	$200.86	$208.02	$299.09
New York Stock Exchange Composite Index	100.00	124.80	138.34	129.88	146.66	180.65
S&P Supercomposite Managed Healthcare Index	100.00	128.05	140.22	187.84	196.95	285.81
Centene Corporation closing stock price	$19.71	$21.17	$25.34	$39.59	$41.00	$58.95
Centene Corporation annual shareholder return		7.4 %	19.7 %	56.2 %	3.6 %	43.8 %

In accordance with the rules of the SEC, the information contained in the Stock Performance Graph on this page shall not be deemed to be “soliciting material,” or to be “filed” with the SEC or subject to the SEC’s Regulation 14A, or to the liabilities of Section 18 of the Exchange Act, except to the extent that Centene specifically requests that the information be treated as soliciting material or specifically incorporates it by reference into a document filed under the Securities Act, or the Exchange Act.

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Item 6. Selected Financial Data

The following selected consolidated financial data should be read in conjunction with the consolidated financial statements and related notes and "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" included in our Annual Report on Form 10-K. The assets, liabilities and results of operations of Kentucky Spirit Health Plan, FirstGuard and University Health Plans have been classified as discontinued operations for all periods presented.

	Year Ended December 31,				
	2013	2012	2011	2010	2009
	(In thousands, except share data)				
Revenues:					
Premium	$10,153,460	$7,568,889	$4,948,137	$4,192,172	$3,786,525
Service	372,580	112,742	103,765	91,661	91,758
Premium and service revenues	10,526,040	7,681,631	5,051,902	4,283,833	3,878,283
Premium tax	337,289	428,665	159,575	164,490	224,581
Total revenues	10,863,329	8,110,296	5,211,477	4,448,323	4,102,864
Expenses:					
Medical costs	8,994,641	6,781,081	4,191,268	3,584,452	3,230,131
Cost of services	326,924	87,705	78,114	63,919	60,789
General and administrative expenses	931,137	677,157	577,898	477,765	447,921
Premium tax expense	333,210	428,354	160,394	165,118	225,888
Impairment loss	—	28,033	—	—	—
Total operating expenses	10,585,912	8,002,330	5,007,674	4,291,254	3,964,729
Earnings from operations	277,417	107,966	203,803	157,069	138,135
Other income (expense):					
Investment and other income	18,457	35,285	13,355	15,205	15,691
Debt extinguishment costs	—	—	(8,488)	—	—
Interest expense	(26,957)	(20,460)	(20,320)	(17,992)	(16,318)
Earnings from continuing operations, before income tax expense	268,917	122,791	188,350	154,282	137,508
Income tax expense	107,080	47,412	70,687	59,900	48,841
Earnings from continuing operations, net of income tax expense	161,837	75,379	117,663	94,382	88,667
Discontinued operations, net of income tax expense (benefit) of $2,284, $(47,741), $(4,165), $4,388, and $(1,204), respectively	3,881	(86,674)	(9,300)	3,889	(2,422)
Net earnings (loss)	165,718	(11,295)	108,363	98,271	86,245
Noncontrolling interest	619	(13,154)	(2,855)	3,435	2,574
Net earnings attributable to Centene Corporation	$165,099	$1,859	$111,218	$94,836	$83,671
Amounts attributable to Centene Corporation common shareholders:					
Earnings from continuing operations, net of income tax expense	$161,218	$88,533	$120,518	$90,947	$86,093
Discontinued operations, net of income tax expense (benefit)	3,881	(86,674)	(9,300)	3,889	(2,422)
Net earnings	$165,099	$1,859	$111,218	$94,836	$83,671

Net earnings (loss) per common share attributable to Centene Corporation:

Basic:

Continuing operations	$2.98	$1.72	$2.40	$1.87	$2.00
Discontinued operations	0.07	(1.68)	(0.18)	0.08	(0.06)
Basic earnings per common share	$3.05	$0.04	$2.22	$1.95	$1.94
Diluted:					
Continuing operations	$2.87	$1.65	$2.30	$1.80	$1.94
Discontinued operations	0.07	(1.62)	(0.18)	0.08	(0.05)
Diluted earnings per common share	$2.94	$0.03	$2.12	$1.88	$1.89
Weighted average number of common shares outstanding:					
Basic	54,126,545	51,509,366	50,198,954	48,754,947	43,034,791
Diluted	56,247,173	53,714,375	52,474,238	50,447,888	44,316,467

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	December 31,				
	2013	2012	2011	2010	2009
	(In thousands)				
Consolidated Balance Sheet Data From Continuing Operations:					
Cash and cash equivalents	$974,304	$745,933	$493,532	$433,914	$400,951
Investments and restricted deposits	940,972	727,157	652,992	639,983	585,183
Total assets	3,413,483	2,534,612	2,092,530	1,937,852	1,668,772
Medical claims liability	1,111,709	815,161	518,840	456,765	470,932
Long term debt	665,697	535,481	348,344	327,824	307,085
Total stockholders' equity	1,243,439	953,767	936,419	797,055	619,427

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ITEM 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Part I, Item 1A."Risk Factors" of this Form 10-K.

OVERVIEW

Our subsidiary, Kentucky Spirit Health Plan (KSHP), ceased serving Medicaid members in Kentucky as of July 6, 2013. Accordingly, the results of operations for KSHP are classified as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise identified.

Our financial performance for 2013 is summarized as follows:

- Year-end at-risk managed care membership of 2,723,200, an increase of 298,700 members, or 12.3% over 2012.
- Premium and service revenues of $10.5 billion, representing 37.0% growth year over year.
- Health Benefits Ratio of 88.6%, compared to 89.6% in 2012.
- General and Administrative expense ratio of 8.8%, compared to 8.8% in 2012.
- Total operating cash flows of $382.5 million, or 2.3 times net earnings.
- Diluted net earnings per share of $2.87, compared to $1.65 in 2012.

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

- AcariaHealth. In April 2013, we completed the acquisition of AcariaHealth, a specialty pharmacy company, for $142.5 million. The transaction consideration was financed through a combination of Centene common stock and cash on hand.

- California. In November 2013, our California subsidiary, California Health and Wellness Plan (CHWP), began operating under a new contract with the California Department of Health Care Services to serve Medicaid beneficiaries in 18 rural counties under the state's Medi-Cal Managed Care Rural Expansion program. Also in November 2013, CHWP began operating under a new contract to serve Medi-Cal beneficiaries in Imperial County.

- Florida. In August 2013, our Florida subsidiary, Sunshine Health, began operating under a contract with the Florida Agency for Health Care Administration to serve members of the Medicaid managed care LTC program. Enrollment began in August 2013 and will be implemented by region and continue through March 2014.

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

- Louisiana. In February 2012, Louisiana Healthcare Connections (LHC), began operating through a joint venture under a new contract in Louisiana to provide healthcare services to Medicaid enrollees participating in the Bayou Health program. LHC completed its three-phase membership roll-out for the three geographical service areas during the second quarter of 2012. In November 2012, the covered services provided by LHC expanded to include pharmacy benefits. During the fourth quarter of 2012, we acquired the ownership interest of our joint venture partner, bringing our ownership to 100%.

- Massachusetts. In July 2013, our joint venture subsidiary, Centurion, began operating under a new contract with the Department of Corrections in Massachusetts to provide comprehensive healthcare services to individuals incarcerated in Massachusetts state correctional facilities. Centurion is a joint venture between Centene and MHM Services Inc.

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

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

- New Hampshire. In December 2013, our subsidiary, New Hampshire Healthy Families, began operating under a new contract with the Department of Health and Human Services to serve Medicaid beneficiaries.

- Ohio. In July 2013, our Ohio subsidiary, Buckeye Community Health Plan (Buckeye), began operating under a new and expanded contract with Ohio Department of Job and Family Services (ODJFS) to serve Medicaid members statewide through Ohio's three newly aligned regions (West, Central/Southeast, and Northeast). Buckeye also began serving members under the ABD Children program in July 2013.

- Tennessee. In September 2013, our joint venture subsidiary, Centurion, began operating under a new contract to provide comprehensive healthcare services to individuals incarcerated in Tennessee state correctional facilities.

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

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

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

- We expect to realize the full year benefit in 2014 of business commenced during 2013 in California, Florida, Massachusetts, New Hampshire, Ohio, and Tennessee as discussed above.

- In February 2014, our Mississippi subsidiary, Magnolia Health Plan, was awarded a statewide managed care contract to continue serving members enrolled in the Mississippi Coordinated Access Network (MississippiCAN) program, as one of two contractors. Under the new contract, Magnolia will continue providing outpatient, behavioral health, pharmacy, vision and dental services, and will also begin providing non-emergency transportation as of July 1, 2014.

- In January 2014, we acquired a majority interest in U.S. Medical Management, LLC, a management services organization and provider of in-home health services for high acuity populations, for approximately $200.0 million. The transaction consideration was financed through a combination of cash on hand and 2,243,217 shares of Centene common stock

- In January 2014, we began serving members enrolled in Health Insurance Marketplaces in certain regions of 9 states: Arkansas, Florida, Georgia, Indiana, Massachusetts, Mississippi, Ohio, Texas and Washington.

- In January 2014, our CeltiCare subsidiary began operating under a new contract with the Massachusetts Executive Office of Health and Human Services to participate in the MassHealth CarePlus program in all five regions.

- In January 2014, Centurion began operating under a new agreement with the Minnesota Department of Corrections to provide managed healthcare services to offenders in the state's correctional facilities.

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In December 2013, we signed a definitive agreement to purchase a majority stake in Fidelis SecureCare of Michigan, Inc. (Fidelis), a subsidiary of Fidelis SeniorCare, Inc. The transaction is expected to close in the fourth quarter of 2014, subject to certain closing conditions including regulatory approvals, and will involve cash purchase price payments contingent on the performance of the plan over the course of 2015. Fidelis was recently selected by the Michigan Department of Community Health to provide integrated healthcare services to members who are dually eligible for Medicare and Medicaid in Macomb and Wayne counties. Enrollment is expected to commence in the fourth quarter of 2014.

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- In November 2013, our South Carolina subsidiary, Absolute Total Care, was selected by the South Carolina Department of Health and Human Services to serve dual-eligible members as part of the state's pilot program to provide integrated and coordinated care for individuals who are eligible for both Medicare and Medicaid. Operations are expected to commence in the second half of 2014.

- In September 2013, the Florida Agency for Health Care Administration provided notice of intent to award a contract to our subsidiary, Sunshine Health, in 9 of 11 regions of the Managed Medical Assistance (MMA) program. The MMA program includes TANF recipients as well as ABD and dual-eligible members. The award is subject to challenge and contract readiness periods, with enrollment expected to begin in the second quarter of 2014 and continue through October 2014. In addition, we were recommended as the sole provider under a contract award for the Child Welfare Specialty Plan (Foster Care), which is expected to commence in the second quarter of 2014.

- In September 2013, we were awarded a contract in Texas from the Texas Health and Human Services Commission to expand our operations and serve STAR+PLUS members in two Medicaid Rural Service Areas. Enrollment is expected to begin in the second half of 2014.

- In November 2012, our Illinois subsidiary, IlliniCare Health Plan, was selected, contingent upon successful completion of contract negotiations, to serve dual-eligible members in Cook, DuPage, Lake, Kane, Kankakee and Will counties (Greater Chicago region) as part of the Illinois Medicare-Medicaid Alignment Initiative. Upon execution of a contract and regulatory approval, enrollment is expected to begin in 2014.

- In August 2012, we were notified by the ODJFS that Buckeye, our Ohio subsidiary, was selected to serve Medicaid members in a dual-eligible demonstration program in three of Ohio's pre-determined seven regions: Northeast (Cleveland), Northwest (Toledo) and West Central (Dayton). This three-year program, which is part of the state of Ohio's Integrated Care Delivery System (ICDS) expansion, will serve those who have both Medicare and Medicaid eligibility. Enrollment is expected to begin in 2014.

In March 2013, we were notified by the Arizona Health Care Cost Containment System (AHCCCS) that our Bridgeway Health Solutions of Arizona, LLC acute care contract was not renewed. As a result, our contract terminated on September 30, 2013. Bridgeway served 16,700 Medicaid acute care members in Yavapai County at September 30, 2013.

MEMBERSHIP

From December 31, 2011 to December 31, 2013, we increased our at-risk managed care membership by 1,087,900, or 66.5%. The following table sets forth our membership by state for our managed care organizations:

	December 31,		
	2013	2012	2011
Arizona	7,100	23,500	23,700
California	97,200	—	—
Florida	222,000	214,000	198,300
Georgia	318,700	313,700	298,200
Illinois	22,300	18,000	16,300
Indiana	195,500	204,000	206,900
Kansas	139,900	—	—
Louisiana	152,300	165,600	—
Massachusetts	22,600	21,500	35,700
Mississippi	78,300	77,200	31,600

Missouri	59,200	59,600	—
New Hampshire	33,600	—	—
Ohio	173,200	157,800	159,900
South Carolina	91,900	90,100	82,900
Tennessee	20,700	—	—
Texas	935,100	949,900	503,800
Washington	82,100	57,200	—
Wisconsin	71,500	72,400	78,000
Total	2,723,200	2,424,500	1,635,300

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

	December 31,		
	2013	2012	2011
Medicaid	2,054,700	1,877,100	1,202,300
CHIP & Foster Care	275,100	235,200	210,600
ABD & Medicare	305,300	274,600	175,100
Hybrid Programs	19,000	29,100	40,500
LTC	37,800	8,500	6,800
Correctional Services	31,300	—	—
Total	2,723,200	2,424,500	1,635,300

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

	December 31,		
	2013	2012	2011
ABD	71,700	62,600	34,400
LTC	28,800	7,700	6,200
Medicare	6,500	5,100	3,200
Total	107,000	75,400	43,800

At December 31, 2013, we also served 156,600 members under our behavioral health contract in Arizona, compared to 157,900 members at December 31, 2012.

From December 31, 2012 to December 31, 2013 our membership increased as a result of:

- operations commencing in California, Kansas and New Hampshire;
- geographic expansion in Ohio;
- growth in Washington; and,
- the commencement of correctional services contracts in Massachusetts and Tennessee.

From December 31, 2011 to December 31, 2012 our membership increased as a result of the commencement of operations in Louisiana, Missouri and Washington as well as the geographic expansion in Texas.

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RESULTS OF OPERATIONS

The following discussion and analysis is based on our consolidated statements of operations, which reflect our results of operations for each of the three years ended December 31, 2013, prepared in accordance with generally accepted accounting principles in the United States ($ in millions):

	2013	2012	2011	% Change 2012-2013	% Change 2011-2012
Premium	$10,153.4	$7,568.9	$4,948.1	34.1 %	53.0 %
Service	372.6	112.7	103.8	230.5 %	8.7 %
Premium and service revenues	10,526.0	7,681.6	5,051.9	37.0 %	52.1 %
Premium tax	337.3	428.7	159.6	(21.3)%	168.6 %
Total revenues	10,863.3	8,110.3	5,211.5	33.9 %	55.6 %
Medical costs	8,994.7	6,781.1	4,191.3	32.6 %	61.8 %
Cost of services	326.9	87.7	78.1	272.8 %	12.3 %
General and administrative expenses	931.1	677.2	577.9	37.5 %	17.2 %
Premium tax expense	333.2	428.4	160.4	(22.2)%	167.1 %
Impairment loss	—	28.0	—	(100.0)%	n.m.
Earnings from operations	277.4	107.9	203.8	156.9 %	(47.0)%
Investment and other income, net	(8.5)	14.8	(15.5)	(157.3)%	195.9 %
Earnings from continuing operations, before income tax expense	268.9	122.7	188.3	119.0 %	(34.8)%
Income tax expense	107.1	47.4	70.7	125.8 %	(32.9)%
Earnings from continuing operations, net of income tax	161.8	75.3	117.6	114.7 %	(35.9)%
Discontinued operations, net of income tax expense (benefit) of $2.3, $(47.7), and $(4.2) respectively	3.9	(86.7)	(9.3)	104.5 %	n.m.
Net earnings (loss)	165.7	(11.4)	108.3	n.m.	(110.4)%
Noncontrolling interest	0.6	(13.2)	(2.9)	104.7 %	(360.7)%
Net earnings attributable to Centene Corporation	$165.1	$1.8	$111.2	n.m.	(98.3)%
Amounts attributable to Centene Corporation common shareholders:					
Earnings from continuing operations, net of income tax expense	$161.2	$88.5	$120.5	82.1 %	(26.5)%
Discontinued operations, net of income tax expense	3.9	(86.7)	(9.3)	104.5 %	n.m.
Net earnings	$165.1	$1.8	$111.2	n.m.	(98.3)%
Diluted earnings (loss) per common share attributable to Centene Corporation:					
Continuing operations	$2.87	$1.65	$2.30	73.9 %	(28.3)%
Discontinued operations	0.07	(1.62)	(0.18)	104.3 %	n.m.
Total diluted earnings per common share	$2.94	$0.03	$2.12	n.m.	(98.6)%

n.m.: not meaningful.

Revenues and Revenue Recognition

Our health plans generate revenues primarily from premiums we receive from the states in which we operate. We generally receive a fixed premium per member per month pursuant to our state contracts. We generally receive premium payments and recognize premium revenue during the month in which we are obligated to provide services to our members. In some instances, our base premiums are subject to an adjustment, or risk score, based on the acuity of our membership. Generally, the risk score is determined by the state analyzing submissions of processed claims data to determine the acuity of our membership relative to the entire state's membership. Some contracts allow for additional premiums associated with certain supplemental services provided such as maternity deliveries.

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Our contracts with states may require us to maintain a minimum health benefits ratio or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to pay a rebate to the state in the event profits exceed established levels. We recognize reductions in revenue in the current period for these programs. Other states may require us to meet certain performance and quality metrics in order to receive additional or full contractual revenue. For performance-based contracts, we do not recognize revenue subject to refund until data is sufficient to measure performance.

Revenues are recorded based on membership and eligibility data provided by the states, which is adjusted on a monthly basis by the states for retroactive additions or deletions to membership data. These eligibility adjustments are estimated monthly and subsequently adjusted in the period known. We continuously review and update those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

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

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

Some states enact premium taxes, similar assessments and provider and hospital pass-through payments, collectively, premium taxes, and these taxes are recorded as a component of revenues as well as operating expenses. We exclude premium taxes from our key ratios as we believe the premium tax is a pass-through of costs and not indicative of our operating performance.

The Centers for Medicare and Medicaid Services (CMS) deploys a risk adjustment model that retroactively apportions Medicare premiums paid according to health severity and certain demographic factors. The model pays more for members whose medical history indicates they have certain medical conditions. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, physician treatment settings as well as prescription drug events. The Company estimates the amount of risk adjustment based upon the diagnosis and pharmacy data submitted and expected to be submitted to CMS and records revenues on a risk adjusted basis.

Operating Expenses

Medical Costs

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

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

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

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

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately predict costs incurred. The health benefits ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding premium taxes) and reflects the direct relationship between the premium received and the medical services provided.

Cost of Services

Cost of services expense includes the pharmaceutical costs associated with our pharmacy benefit manager and specialty pharmacy's external revenues and certain direct costs to support the functions responsible for generation of our service revenues. These expenses consist of the salaries and wages of the professionals who provide the services and associated expenses.

General and Administrative Expenses

General and administrative expenses, or G&A, primarily reflect wages and benefits, including stock compensation expense, and other administrative costs associated with our health plans, specialty companies and centralized functions that support all of our business units. Our major centralized functions are finance, information systems and claims processing. G&A expenses also include business expansion costs, such as wages and benefits for administrative personnel, contracting costs, and information technology buildouts, incurred prior to the commencement of a new contract or health plan.

The G&A expense ratio represents G&A expenses as a percentage of premium and service revenues, and reflects the relationship between revenues earned and the costs necessary to earn those revenues.

Other Income (Expense)

Other income (expense) consists principally of investment income from cash and investments, earnings in equity method investments, and interest expense on debt.

Discontinued Operations

Our subsidiary, Kentucky Spirit Health Plan (KSHP), ceased serving Medicaid members in Kentucky as of July 6, 2013. Accordingly, the results of operations for KSHP are classified as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis is presented primarily in the context of continuing operations unless otherwise identified.

Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

Premium and Service Revenues

Premium and service revenues increased 37.0% in the year ended December 31, 2013 over the corresponding period in 2012 as a result of the Texas, Mississippi, Louisiana and Florida expansions, pharmacy carve-ins in Texas and Louisiana, the additions of the Kansas, Missouri, Washington, California and New Hampshire contracts, commencement of the correctional healthcare contracts in Massachusetts and Tennessee, rate increases in several of our markets and the acquisition of AcariaHealth. During the year ended December 31, 2013, we received premium rate adjustments which yielded a net 2.7% composite increase across all of our markets.

Premium Tax Revenue

Premium tax revenue decreased 21.3% in the year ended December 31, 2013 over the corresponding period in 2012. This is as a result of one of our states paying us approximately $180 million in 2012 to pay to specified providers.

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Operating Expenses

Medical Costs

The table below depicts the HBR for our membership by member category for the year ended December 31,:

	2013	2012
Medicaid and CHIP	87.5 %	88.8 %
ABD and Medicare	90.4	90.7
Specialty Services	85.4	92.0
Total	88.6	89.6

The consolidated HBR for the year ended December 31, 2013, of 88.6% was a decrease of 100 basis points over the comparable period in 2012. The 2013 HBR reflects performance improvement in Texas and our individual insurance business from 2012.

Cost of Services

Cost of services increased by $239.2 million in the year ended December 31, 2013, compared to the corresponding period in 2012. This was primarily due to the additional volume resulting from the acquisition of AcariaHealth.

General & Administrative Expenses

General and administrative expenses, or G&A, increased by $254.0 million in the year ended December 31, 2013, compared to the corresponding period in 2012. This was primarily due to expenses for additional staff and facilities to support our membership growth, AcariaHealth transaction costs, as well as performance based compensation.

The consolidated G&A expense ratio for the years ended December 31, 2013 and 2012 was 8.8% and 8.8% respectively. The G&A expense ratio reflects an increase in performance based compensation expense in 2013 as well as AcariaHealth transaction costs, offset by the benefits of leveraging of expenses over higher revenue in 2013 and our efforts to control costs.

Other Income (Expense)

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

	2013	2012
Investment income	$18.5	$15.9
Gain on sale of investments	—	1.5
Gain on sale of investment in convertible note	—	17.9
Interest expense	(27.0)	(20.5)
Other income (expense), net	$(8.5)	$14.8

Investment income. The increase in investment income in 2013 primarily reflects an increase in investment balances over 2012.

Gain on sale of investments. During 2012, we recognized $1.5 million in net gains primarily as a result of the liquidation of $75.5 million of investments held by the Georgia health plan in order to meet short term liquidity needs due to delays in premium receipts from the state.

Gain on sale of investment in convertible note. During 2012, we executed an agreement with a third party borrower whereby the borrower agreed to pay us total consideration of $50.0 million for retirement of $30.0 million of outstanding notes and equity ownership conversion features in certain Medicaid and Medicare related businesses. As a result, we recorded a pre-tax gain of $17.9 million in other income representing the fair value of the total consideration in excess of the carrying value of the loans on the balance sheet.

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Interest expense. Interest expense increased during the year ended December 31, 2013 by $6.5 million reflecting the addition of $175 million of Senior Notes in the fourth quarter of 2012.

Income Tax Expense

Excluding the effects of noncontrolling interests, our effective tax rate for the year ended December 31, 2013 was 39.9% compared to 34.9% in 2012. The increase in the income tax rate over 2012 resulted from a tax benefit in 2012 resulting from the clarification by a state taxing authority regarding a state income tax calculation, partially offset by a non-deductible goodwill impairment in 2012.

Segment Results

The following table summarizes our operating results by segment for the year ended December 31, (in millions):

	2013	2012	% Change 2012-2013
Premium and Service Revenues			
Managed Care	$9,781.8	$7,212.0	35.6 %
Specialty Services	2,932.5	2,107.0	39.2 %
Eliminations	(2,188.3)	(1,637.4)	(33.6)%
Consolidated Total	$10,526.0	$7,681.6	37.0 %
Earnings from Operations			
Managed Care	$197.8	$62.9	214.7 %
Specialty Services	79.6	45.1	76.4 %
Consolidated Total	$277.4	$108.0	156.9 %

Managed Care

Premium and service revenues increased 35.6% in the year ended December 31, 2013, due to the Texas, Mississippi, Louisiana and Florida expansions, pharmacy carve-ins in Texas and Louisiana, the additions of the California, Kansas, Missouri, New Hampshire and Washington contracts and rate increases in several of our markets. Earnings from operations increased $134.9 million in the year ended December 31, 2013, primarily due to improvements in the performance of the Texas business from 2012.

Specialty Services

Premium and service revenues increased 39.2% in the year ended December 31, 2013, due to the carve-in of pharmacy services in Texas and Louisiana, growth in our Medicaid segment and the associated services provided to this increased membership, the acquisition of AcariaHealth and the additions of the Centurion contracts in Massachusetts and Tennessee. Earnings from operations increased $34.5 million in the year ended December 31, 2013. This reflects improvement in our individual health insurance business in 2013 and the impact of a $28.0 million impairment loss in 2012 in our individual insurance business.

Year Ended December 31, 2012 Compared to Year Ended December 31, 2011

Revenues

Premium and service revenues increased 52.1% in the year ended December 31, 2012 over the corresponding period in 2011 as a result of the additional revenue from our Illinois, Louisiana, Mississippi, Missouri and Washington contracts, Texas and Arizona expansions, pharmacy carve-ins in Texas and Ohio, and organic membership growth.

During the year ended December 31, 2012, we received premium rate adjustments which yielded a net 2.6% composite increase across all of our markets.

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Operating Expenses

Medical Costs

The table below depicts the HBR for our membership by member category for the year ended December 31,:

	2012	2011
Medicaid and CHIP	88.8 %	82.0 %
ABD and Medicare	90.7	90.1
Specialty Services	92.0	86.2
Total	89.6	84.7

The consolidated HBR for the year ended December 31, 2012, of 89.6% was an increase of 490 basis points over the comparable period in 2011. The increase compared to last year primarily reflects (1) a high level of medical costs in the March 1, 2012 expansion areas in Texas, (2) a high level of medical costs in our individual health business, especially for policies issued to members who converted in the first quarter of 2012 and (3) a high level of flu costs during the fourth quarter of 2012.

General and Administrative Expenses

General and administrative expenses, or G&A, increased by $99.3 million in the year ended December 31, 2012, compared to the corresponding period in 2011. This was primarily due to expenses for additional staff and facilities to support our membership growth, partially offset by a reduction in performance based compensation expense in 2012.

The consolidated G&A expense ratio for the years ended December 31, 2012 and 2011 was 8.8% and 11.4% respectively. The year over year decrease in the G&A expense ratio reflects the leveraging of expenses over higher revenues in 2012 and a reduction in performance based compensation expense in 2012 which lowered the G&A expense ratio by approximately 60 basis points.

Impairment Loss

During 2011, the Company completed its annual goodwill and intangible asset impairment testing and concluded that the fair value of all reporting units with material amounts of goodwill was substantially in excess of the carrying value as of our impairment testing date. Specifically, the Company tested its Celtic reporting unit under a quantitative model which included anticipated financial performance for new business to be converted in 2012. Under the quantitative model, the testing revealed that the carrying value exceeded fair value of the Celtic reporting unit by approximately 190%.

During 2012, our subsidiary, Celtic Insurance Company, experienced a high level of medical costs for individual health policies, especially for recently issued policies related to members converted from another insurer during the first quarter of 2012. Additionally, in June 2012, the U.S. Supreme Court upheld the constitutionality of the Patient Protection and Affordable Care Act. The Affordable Care Act, among other things, limits the profitability of the individual health insurance business because of minimum medical loss ratios, guaranteed issue policies, and increased competition in the Marketplace product. As a result of these factors, our expectations for future growth and profitability were lower than previous estimates and we conducted an impairment analysis of the identifiable intangible assets and goodwill of the Celtic reporting unit. The impairment analysis resulted in goodwill and intangible asset impairments of $28.0 million, recorded as an impairment loss in the consolidated statement of operations. The impaired identifiable intangible assets of $2.3 million and goodwill of $25.7 million were reported under the Specialty Services segment; $26.6 million of the impairment loss is not deductible for income tax purposes.

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Investment and Other Income, Net

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

	2012	2011
Investment income	$15.9	$13.0
Gain on sale of investments	1.5	0.3
Gain on sale of investment in convertible note	17.9	—
Debt extinguishment costs	—	(8.5)
Interest expense	(20.5)	(20.3)
Other income (expense), net	$14.8	$(15.5)

Investment income. The increase in investment income in 2012 primarily reflects higher investment balances in 2012.

Gain on sale of investments. During the year ended December 31, 2012, we recognized $1.5 million in net gains primarily as a result of the liquidation of $75.5 million of investments held by the Georgia health plan in order to meet short term liquidity needs due to delays in premium receipts from the state.

Gain on sale of investment in convertible note. Between July 2008 and October 2011, we made an investment of $30.0 million in secured notes receivable to a third party as part of an investment in certain Medicaid and Medicare related businesses. The notes included a feature to convert the note balance into an equity ownership in the underlying businesses. In September 2012, we executed an agreement with the borrower whereby the borrower agreed to pay us total consideration of $50.0 million for retirement of the outstanding notes and equity ownership conversion feature. As a result, during the third quarter of 2012, we recorded a pre-tax gain of $17.9 million in other income representing the fair value of the total consideration in excess of the carrying value of the loans on the balance sheet.

Interest expense. Interest expense increased during the year ended December 31, 2012 by $0.2 million reflecting the issuance of an additional $175 million in Senior Notes in November 2012, partially offset by the refinancing of our $250 million Senior Notes and execution of the associated interest rate swap agreement in May 2011.

Income Tax Expense

Excluding the effects of noncontrolling interests, our effective tax rate for 2012 was 34.9% compared to 37.0% in 2011.
The tax rate for the year ended December 31, 2012, reflects a tax benefit resulting from the clarification by a state taxing authority regarding a state income tax calculation, partially offset by Celtic's non-deductible goodwill impairment.

Segment Results

The following table summarizes our operating results by segment for the year ended December 31, (in millions):

	2012	2011	% Change 2011-2012
Premium and Service Revenues			
Managed Care	$7,212.0	$4,636.2	55.6%
Specialty Services	2,107.0	1,190.5	77.0%
Eliminations	(1,637.4)	(774.8)	(111.3)%
Consolidated Total	$7,681.6	$5,051.9	52.1%
Earnings from Operations			

Managed Care	$62.9	$161.9	(61.2)%
Specialty Services	45.1	41.9	7.6 %
Consolidated Total	$108.0	$203.8	(47.0)%

Managed Care

Premium and service revenues increased 55.6% in the year ended December 31, 2012, due to the addition of our Illinois, Louisiana, Mississippi, Missouri and Washington contracts, Texas expansion, pharmacy carve-ins in Texas and Ohio, and organic membership growth. Earnings from operations decreased $99.0 million in the year ended December 31, 2012,

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primarily due to higher medical costs in our Texas health plan specifically in the expansion areas and increased flu costs during the fourth quarter of 2012.

Specialty Services

Premium and service revenues increased 77.0% in the year ended December 31, 2012, due to (1) the carve-in of pharmacy services in Texas and Ohio, (2) Specialty Company revenue related to the growth in our Medicaid segment and the associated specialty services provided to this increased membership and (3) the Arizona expansion. Earnings from operations increased $3.2 million in the year ended December 31, 2012, reflecting growth in our pharmacy business and the associated specialty services provided to our increased Medicaid membership, partially offset by the impairment loss of $28.0 million recorded in 2012 and a high level of medical costs in Celtic Insurance Company, especially for members converted in the first quarter of 2012.

LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows for the years ended December 31, 2013, 2012 and 2011, used in the discussion of liquidity and capital resources ($ in millions).

	Year Ended December 31,		
	2013	2012	2011
Net cash provided by operating activities	$382.5	$278.7	$261.7
Net cash used in investing activities	(342.1)	(187.9)	(129.1)
Net cash provided by financing activities	153.7	179.5	6.9
Net increase in cash and cash equivalents	$194.1	$270.3	$139.5

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our revolving credit facility.

Cash flows from operating activities for 2013 increased $103.8 million, or 37% compared to 2012 due to an increase in net earnings between years and growth in our business. Additionally, incentive compensation accruals increased from 2012 due to the performance of the Company. This accrual will be paid during the first and second quarter of 2014.

Cash flows from operating activities for 2012 increased $17.0 million, or 6% compared to 2011 driven by lower net earnings that were partially offset by the growth in medical claims liabilities associated with business expansions.

Cash flows from operations in each year were impacted by the timing of payments we receive from our states. States may prepay the following month premium payment, which we record as unearned revenue, or they may delay our premium payment, which we record as a receivable. We typically receive capitation payments monthly, however the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period. The table below details the impact to cash flows from operations from the timing of payments from our states ($ in millions).

	Year Ended December 31,		
	2013	2012	2011
Premium and related receivables	$(143.0)	$(116.6)	$(11.3)
Unearned revenue	2.7	24.7	(109.1)
Net decrease in operating cash flow	$(140.3)	$(91.9)	$(120.4)

Net cash provided by operating activities in 2011 was negatively impacted by the timing of payments from our states by $120.4 million. As of December 31, 2011, we had received all December 2011 capitation payments from our states and had not received any prepayments of January 2012 capitation. This was offset by an increase in medical claims liabilities related to the start up of our Mississippi, Illinois and Kentucky health plans, as well as expansion of our Texas health plan in 2011.

Cash Flows Used in Investing Activities

Cash flows used in investing activities in 2013 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long term investments, the acquisition of AcariaHealth and

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capital expenditures. We completed the acquisition of AcariaHealth in April 2013 for $142.5 million in total consideration. The transaction was financed through a combination of Centene common stock as well as $67.1 million cash on hand. During 2012 and 2011, our investing activities primarily related to additions to the investment portfolio of our regulated subsidiaries and capital expenditures.

Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets within our guidelines. Net cash provided by and used in investing activities will fluctuate from year to year due to the timing of investment purchases, sales and maturities. As of December 31, 2013, our investment portfolio consisted primarily of fixed-income securities with an average duration of 2.9 years. These securities generally are actively traded in secondary markets and the reported fair market value is determined based on recent trading activity, recent trading activity in similar securities and other observable inputs. Our investment guidelines comply with the regulatory restrictions enacted in each state. We had unregulated cash and investments of $44.7 million at December 31, 2013, compared to $37.3 million at December 31, 2012.

We spent $67.8 million, $82.1 million and $73.7 million in 2013, 2012 and 2011 respectively, on capital expenditures for system enhancements, a new datacenter and market expansions including $20.9 million in 2012 for land in close proximity to our corporate headquarters to support future growth.

Cash Flows Provided by Financing Activities

Our financing activities provided cash of $153.7 million, $179.5 million and $6.9 million in 2013, 2012 and 2011 respectively. Financing activities in 2013, 2012 and 2011 are discussed below.

2013. During 2013, our financing activities primarily related to borrowings under our revolving credit facility, the sale of $15.2 million of common stock to fund the escrow account for the acquisition of AcariaHealth and the repayment of a mortgage note.

In May 2013, we entered into a new unsecured $500 million revolving credit facility and terminated our previous $350 million revolving credit facility. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement has a maturity date of June 1, 2018, provided it will mature 90 days prior to the maturity date of the 5.75% Senior Notes due 2017 if such notes are not refinanced (or extended) or certain financial conditions are not met, including carrying $100 million of unrestricted cash on deposit. As of December 31, 2013, we had $150.0 million in borrowings outstanding under our revolving credit facility, and we were in compliance with all covenants.

2012. In November 2012, pursuant to a shelf registration statement, we issued an additional $175 million of non-callable 5.75% Senior Notes due June 1, 2017 ($175 million Add-on Notes) at a premium to yield 4.29%. The indenture governing the $175 million Add-on Notes contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio. Interest is paid semi-annually in June and December. We used the net proceeds from the offering to make capital contributions to our regulated subsidiaries.

2011. In January 2011, we replaced our $300 million revolving credit agreement with a new $350 million revolving credit facility, or the revolver. The revolver was unsecured and had a five-year maturity with non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt to EBITDA ratios and minimum net worth. Borrowings under the revolver bore interest based upon LIBOR rates, the Federal funds rate, or the prime rate. There was a commitment fee on the unused portion of the agreement that ranges from 0.25% to 0.50% depending on the total debt to EBITDA ratio.

In May 2011, we exercised our option to redeem the $175 million 7.25% Senior Notes due April 1, 2014 ($175 million Notes). We redeemed the $175 million Notes at 103.625% and wrote off unamortized debt issuance costs, resulting in a pre-tax expense of $8.5 million.

In May 2011, pursuant to a shelf registration statement, we issued $250 million of non-callable 5.75% Senior Notes due June 1, 2017 ($250 million Notes) at a discount to yield 6%. The indenture governing the $250 million Notes contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio. Interest is paid semi-annually in June and December. We used a portion of the net proceeds from the offering to repay the $175 million Notes and call premium and to repay approximately $50 million outstanding on our revolving credit facility. The additional proceeds were used for general corporate purposes. In connection with the issuance, we entered into $250 million notional amount of interest rate swap agreements (Swap Agreements) that are scheduled to expire June 1, 2017. Under the Swap Agreements, we receive a fixed rate of 5.75% and pay a variable rate of LIBOR plus 3.5% adjusted quarterly, which allows us to adjust the $250 million Notes to a floating rate. We do not hold or issue any derivative instrument for trading or speculative purposes.

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Liquidity Metrics

The $500 million revolving credit agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. We are required not to exceed a maximum debt-to-EBITDA ratio of 3.0 to 1.0. As of December 31, 2013, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

We had outstanding letters of credit of $28.8 million as of December 31, 2013, which were not part of our revolving credit facility and bore interest at 0.51%. In addition, we had outstanding surety bonds of $102.6 million as of December 31, 2013.

At December 31, 2013, we had working capital, defined as current assets less current liabilities, of $241.1 million, as compared to $176.5 million at December 31, 2012. We manage our short term and long term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short term requirements as needed.

At December 31, 2013, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 35.0%, compared to 36.1% at December 31, 2012. Excluding the $72.8 million non-recourse mortgage note, our debt to capital ratio is 32.4%, compared to 32.7% at December 31, 2012. We utilize the debt to capital ratio as a measure, among others, of our leverage and financial flexibility.

We have a stock repurchase program authorizing us to repurchase up to four million shares of common stock from time to time on the open market or through privately negotiated transactions. We have 1.7 million available shares remaining under the program for repurchases as of December 31, 2013. No duration has been placed on the repurchase program. We reserve the right to discontinue the repurchase program at any time. We did not make any repurchases under this plan during 2013 or 2012.

During the year ended December 31, 2013, 2012 and 2011, we received dividends of $18.0 million, $29.0 million, and $69.1 million, respectively, from our regulated subsidiaries.

2014 Expectations

In January 2014, we acquired a majority interest in U.S. Medical Management, LLC, a leading management services organization and provider of in-home health services for high acuity populations, for approximately $200.0 million. The transaction consideration was financed through a combination of cash on hand and 2,243,217 shares of Centene common stock.

In December 2013, we signed a definitive agreement to purchase a majority stake in Fidelis SecureCare of Michigan, Inc., a subsidiary of Fidelis SeniorCare, Inc. The transaction is expected to close in the fourth quarter of 2014, subject to certain closing conditions including regulatory approvals, and will involve cash purchase price payments contingent on the performance of the plan over the course of 2015.

We expect to make capital contributions to our insurance subsidiaries of approximately $350 million during 2014 associated with our growth and spend approximately $95 million in additional capital expenditures primarily associated with system enhancements and market expansions. These capital contributions are expected to be funded by unregulated cash flow generation in 2014 and borrowings on our revolving credit facility.

Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our credit facility, along with the issuance of shares of Centene common stock in connection with the acquisition of U.S. Medical Management, LLC discussed above will be sufficient to finance our general operations, planned acquisition of U.S. Medical Management, LLC and capital expenditures for at least 12 months from the date of this filing.

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CONTRACTUAL OBLIGATIONS

The following table summarizes future contractual obligations. These obligations contain estimates and are subject to revision under a number of circumstances. Our debt consists of borrowings from our senior notes, credit facility, mortgages and capital leases. The purchase obligations consist primarily of software purchases and maintenance contracts. The contractual obligations and estimated period of payment over the next five years and beyond are as follows (in thousands):

	Payments Due by Period				
	Total	Less Than 1 Year	1-3 Years	3-5 Years	More Than 5 Years
Medical claims liability	$1,111,709	$1,111,709	$—	$—	$—
Debt and interest	775,385	31,180	62,331	600,725	81,149
Operating lease obligations	126,186	25,350	50,073	31,963	18,800
Purchase obligations	51,549	28,404	19,424	2,732	989
Other long term liabilities 1	—	—	—	—	—
Total	$2,064,829	$1,196,643	$131,828	$635,420	$100,938

[1] Our Consolidated Balance Sheet as of December 31, 2013, includes $60,015 of other long term liabilities. This consists primarily of long term deferred income taxes, liabilities under our deferred compensation plan, and reserves for uncertain tax positions. These liabilities have been excluded from the table above as the timing and/or amount of any cash payment is uncertain. As of December 31, 2013, reserves for uncertain tax positions totaled $3,274. See the "Income Taxes" footnote for additional information regarding our deferred tax positions and accruals for uncertain tax positions. Other long term liabilities also include $6,888 separate account liabilities from third party reinsurance that will not be settled in cash.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

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

Our subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of December 31, 2013, our subsidiaries, including Kentucky Spirit Health Plan, had aggregate statutory capital and surplus of $1,279.7 million, compared with the required minimum aggregate statutory capital and surplus requirements of $686.4 million. During the year ended December 31, 2013, we contributed $426 million of statutory capital to our subsidiaries. We estimate our Risk Based Capital, or RBC, percentage to be in excess of 350% of the Authorized Control Level.

The National Association of Insurance Commissioners has adopted rules which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of December 31, 2013, each of our health plans was in compliance with the risk-based capital requirements enacted in those states.

RECENT ACCOUNTING PRONOUNCEMENTS

For this information, refer to Note 2, Summary of Significant Accounting Policies, in the Notes to the Consolidated Financial Statements, included herein.

CRITICAL ACCOUNTING POLICIES AND ESTIMATES

Our discussion and analysis of our results of operations and liquidity and capital resources are based on our consolidated financial statements which have been prepared in accordance with GAAP. Our significant accounting policies are more fully described in Note 2, Summary of Significant Accounting Policies, to our consolidated financial statements included elsewhere herein. Our accounting policies regarding medical claims liability and intangible assets are particularly important to the portrayal of our financial position and results of operations and require the application of significant judgment by our management. As a result, they are subject to an inherent degree of uncertainty. We have reviewed these critical accounting policies and related disclosures with the Audit Committee of our Board of Directors.

Medical Claims Liability

Our medical claims liability includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. We estimate our medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Actuarial Standards of Practice generally require that the medical claims liability estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amounts ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. We include in our IBNR an estimate for medical claims liability under moderately adverse conditions which represents the risk of adverse deviation of the estimates in our actuarial method of reserving.

We use our judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions we consider when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to fee schedules, and the incidence of high dollar or catastrophic claims.

We apply various estimation methods depending on the claim type and the period for which claims are being estimated. For more recent periods, incurred non-inpatient claims are estimated based on historical per member per month claims experience adjusted for known factors. Incurred hospital inpatient claims are estimated based on known inpatient utilization data and prior claims experience adjusted for known factors. For older periods, we utilize an estimated completion factor based on our historical experience to develop IBNR estimates. The completion factor is an actuarial estimate of the percentage of claims incurred during a given period that have been received or adjudicated as of the reporting period to the estimate of the total ultimate incurred costs. When we commence operations in a new state or region, we have limited information with which to estimate our medical claims liability. See “Risk Factors - Failure to accurately predict our medical expenses could negatively affect our financial position, results of operations or cash flows.” These approaches are consistently applied to each period presented.

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

Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as additional claims receipts and payment information becomes available. As more complete claims information becomes available, we adjust the amount of the estimates, and include the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, our operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. We consistently apply our reserving methodology from period to period. As additional information becomes known to us, we adjust our actuarial models accordingly to establish medical claims liability estimates.

The paid and received completion factors, claims per member per month and per diem cost trend factors are the most significant factors affecting the IBNR estimate. The following table illustrates the sensitivity of these factors and the estimated potential impact on our operating results caused by changes in these factors based on December 31, 2013 data:

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Completion Factors (1):		Cost Trend Factors (2):	
(Decrease) Increase in Factors	Increase (Decrease) in Medical Claims Liabilities (in thousands)	(Decrease) Increase in Factors	Increase (Decrease) in Medical Claims Liabilities (in thousands)
(2.0)%	$137,100	(2.0)%	$(36,800)
(1.5)	102,300	(1.5)	(27,700)
(1.0)	67,800	(1.0)	(18,500)
(0.5)	33,800	(0.5)	(9,200)
0.5	(33,500)	0.5	9,200
1.0	(66,500)	1.0	18,700
1.5	(99,100)	1.5	28,000
2.0	(131,600)	2.0	37,300

(1) Reflects estimated potential changes in medical claims liability caused by changes in completion factors.

(2) Reflects estimated potential changes in medical claims liability caused by changes in cost trend factors for the most recent periods.

While we believe our estimates are appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. For example, a 1% increase or decrease in our estimated medical claims liability would have affected net earnings by $7.0 million for the year ended December 31, 2013. The estimates are based on our historical experience, terms of existing contracts, our observance of trends in the industry, information provided by our providers and information available from other outside sources.

The change in medical claims liability is summarized as follows (in thousands):

	Year Ended December 31,		
	2013	2012	2011
Balance, January 1,	$815,161	$518,840	$456,765
Incurred related to:			
Current year	9,072,867	6,836,177	4,256,645
Prior years	(78,226)	(55,096)	(65,377)
Total incurred	8,994,641	6,781,081	4,191,268
Paid related to:			
Current year	7,975,367	6,024,720	3,744,475
Prior years	722,726	460,040	384,718
Total paid	8,698,093	6,484,760	4,129,193
Balance, December 31,	$1,111,709	$815,161	$518,840
Claims inventory, December 31	622,200	619,200	432,200
Days in claims payable [1]	42.4	38.5	43.4

[1] Days in claims payable is a calculation of medical claims liability at the end of the period divided by average expense per calendar day for the fourth quarter of each year.

Medical claims are usually paid within a few months of the member receiving service from the physician or other healthcare provider. As a result, the liability generally is described as having a “short-tail,” which causes less than 5%

of our medical claims liability as of the end of any given year to be outstanding the following year. We believe that substantially all the development of the estimate of medical claims liability as of December 31, 2013 will be known by the end of 2014.

Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. In addition, claims processing initiatives yielded increased claim payment recoveries and coordination of benefits

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related to prior year dates of service. Changes in medical utilization and cost trends and the effect of medical management initiatives may also contribute to changes in medical claim liability estimates. While we have evidence that medical management initiatives are effective on a case by case basis, medical management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care, or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the medical management initiative are not known by us. Additionally, certain medical management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the medical management initiative changed the behavior cannot be determined. Because of the complexity of our business, the number of states in which we operate, and the volume of claims that we process, we are unable to practically quantify the impact of these initiatives on our changes in estimates of IBNR.

The following are examples of medical management initiatives that may have contributed to the favorable development through lower medical utilization and cost trends:

- Appropriate leveling of care for neonatal intensive care unit hospital admissions, other inpatient hospital admissions, and observation admissions, in accordance with Interqual or other criteria.
- Tightening of our pre-authorization list and more stringent review of durable medical equipment and injectibles.
- Emergency department, or ED, program designed to collaboratively work with hospitals to steer non-emergency care away from the costly ED setting (through patient education, on-site alternative urgent care settings, etc.)
- Increase emphasis on case management and clinical rounding where case managers are nurses or social workers who are employed by the health plan to assist selected patients with the coordination of healthcare services in order to meet a patient's specific healthcare needs.
- Incorporation of disease management which is a comprehensive, multidisciplinary, collaborative approach to chronic illnesses such as asthma.
- Prenatal and infant health programs utilized in our Start Smart For Your Baby outreach service.

Goodwill and Intangible Assets

We have made several acquisitions that have resulted in our recording of intangible assets. These intangible assets primarily consist of customer relationships, purchased contract rights, provider contracts, trade names and goodwill. At December 31, 2013, we had $348.4 million of goodwill and $48.8 million of other intangible assets.

Intangible assets are amortized using the straight-line method over the following periods:

Intangible Asset	Amortization Period
Purchased contract rights	5 - 15 years
Provider contracts	4 - 15 years
Customer relationships	5 - 15 years
Trade names	7 - 20 years

Our management evaluates whether events or circumstances have occurred that may affect the estimated useful life or the recoverability of the remaining balance of goodwill and other identifiable intangible assets. If the events or circumstances indicate that the remaining balance of the intangible asset or goodwill may be impaired, the potential impairment will be measured based upon the difference between the carrying amount of the intangible asset or goodwill and the fair value of such asset. Our management must make assumptions and estimates, such as the discount factor, future utility and other internal and external factors, 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.

Goodwill is reviewed annually during the fourth quarter for impairment. In addition, an impairment analysis of intangible assets would be performed based on other factors. These factors include significant changes in membership, state funding, medical contracts and provider networks and contracts. The fair value of all reporting units with material amounts of goodwill was substantially in excess of the carrying value as of our annual impairment testing date.

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ITEM 7A. Quantitative and Qualitative Disclosures About Market Risk.

INVESTMENTS AND DEBT

As of December 31, 2013, we had short term investments of $102.1 million and long term investments of $838.8 million, including restricted deposits of $46.9 million. The short term investments generally consist of highly liquid securities with maturities between three and 12 months. The long term investments consist of municipal, corporate and U.S. Treasury securities, government sponsored obligations, life insurance contracts, asset backed securities and equity securities and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long term regardless of the contractual maturity date. Substantially all of our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2013, the fair value of our fixed income investments would decrease by approximately $23.2 million. Declines in interest rates over time will reduce our investment income.

We entered into interest rate swap agreements with creditworthy financial institutions to manage the impact of market interest rates on interest expense. Our swap agreements convert a portion of our interest expense from fixed to variable rates to better match the impact of changes in market rates on our variable rate cash equivalent investments. As a result, the fair value of our $250 million Senior Note debt varies with market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2013, the fair value of our debt would decrease by approximately $8.3 million. An increase in interest rates decreases the fair value of the debt and conversely, a decrease in interest rates increases the value.

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

INFLATION

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

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

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Item 8. Financial Statements and Supplementary Data

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Centene Corporation:

We have audited the accompanying consolidated balance sheets of Centene Corporation and subsidiaries as of December 31, 2013 and 2012, and the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the three year period ended December 31, 2013. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Centene Corporation and subsidiaries as of December 31, 2013 and 2012, and the results of their operations and their cash flows for each of the years in the three year period ended December 31, 2013, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Centene Corporation's internal control over financial reporting as of December 31, 2013, based on criteria established in Internal Control - Integrated Framework (1992) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated February 21, 2014 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

/s/ KPMG LLP

St. Louis, Missouri
February 21, 2014

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CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(In thousands, except share data)

	December 31, 2013	December 31, 2012
ASSETS		
Current assets:		
Cash and cash equivalents of continuing operations	$974,304	$745,933
Cash and cash equivalents of discontinued operations	63,769	98,019
Total cash and cash equivalents	1,038,073	843,952
Premium and related receivables	428,570	251,473
Short term investments	102,126	138,101
Other current assets	217,661	93,322
Other current assets of discontinued operations	13,743	78,977
Total current assets	1,800,173	1,405,825
Long term investments	791,900	554,770
Restricted deposits	46,946	34,286
Property, software and equipment, net	395,407	375,893
Goodwill	348,432	256,288
Intangible assets, net	48,780	20,268
Other long term assets	59,357	64,278
Long term assets of discontinued operations	38,305	62,297
Total assets	$3,529,300	$2,773,905
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$1,111,709	$815,161
Accounts payable and accrued expenses	375,862	219,066
Unearned revenue	38,191	34,597
Current portion of long term debt	3,065	3,373
Current liabilities of discontinued operations	30,294	157,116
Total current liabilities	1,559,121	1,229,313
Long term debt	665,697	535,481
Other long term liabilities	60,015	54,987
Long term liabilities of discontinued operations	1,028	357
Total liabilities	2,285,861	1,820,138
Commitments and contingencies		
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; 58,673,215 issued and 55,319,239 outstanding at December 31, 2013, and 55,339,160 issued and 52,329,248 outstanding at December 31, 2012	59	55
Additional paid-in capital	594,326	450,856
Accumulated other comprehensive income:		
Unrealized (loss) gain on investments, net of tax	(2,620)	5,189
Retained earnings	731,919	566,820
Treasury stock, at cost (3,353,976 and 3,009,912 shares, respectively)	(89,643)	(69,864)
Total Centene stockholders' equity	1,234,041	953,056
Noncontrolling interest	9,398	711
Total stockholders' equity	1,243,439	953,767

Total liabilities and stockholders' equity	$3,529,300	$2,773,905

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

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CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS
(In thousands, except share data)

	Year Ended December 31, 2013	2012	2011
Revenues:			
Premium	$10,153,460	$7,568,889	$4,948,137
Service	372,580	112,742	103,765
Premium and service revenues	10,526,040	7,681,631	5,051,902
Premium tax	337,289	428,665	159,575
Total revenues	10,863,329	8,110,296	5,211,477
Expenses:			
Medical costs	8,994,641	6,781,081	4,191,268
Cost of services	326,924	87,705	78,114
General and administrative expenses	931,137	677,157	577,898
Premium tax expense	333,210	428,354	160,394
Impairment loss	—	28,033	—
Total operating expenses	10,585,912	8,002,330	5,007,674
Earnings from operations	277,417	107,966	203,803
Other income (expense):			
Investment and other income	18,457	35,285	13,355
Debt extinguishment costs	—	—	(8,488)
Interest expense	(26,957)	(20,460)	(20,320)
Earnings from continuing operations, before income tax expense	268,917	122,791	188,350
Income tax expense	107,080	47,412	70,687
Earnings from continuing operations, net of income tax expense	161,837	75,379	117,663
Discontinued operations, net of income tax expense (benefit) of $2,284, $(47,741), and $(4,165), respectively	3,881	(86,674)	(9,300)
Net earnings (loss)	165,718	(11,295)	108,363
Noncontrolling interest	619	(13,154)	(2,855)
Net earnings attributable to Centene Corporation	$165,099	$1,859	$111,218
Amounts attributable to Centene Corporation common shareholders:			
Earnings from continuing operations, net of income tax expense	$161,218	$88,533	$120,518
Discontinued operations, net of income tax expense (benefit)	3,881	(86,674)	(9,300)
Net earnings	$165,099	$1,859	$111,218
Net earnings (loss) per common share attributable to Centene Corporation:			
Basic:			
Continuing operations	$2.98	$1.72	$2.40
Discontinued operations	0.07	(1.68)	(0.18)
Basic earnings per common share	$3.05	$0.04	$2.22
Diluted:			
Continuing operations	$2.87	$1.65	$2.30
Discontinued operations	0.07	(1.62)	(0.18)
Diluted earnings per common share	$2.94	$0.03	$2.12

Weighted average number of common shares outstanding:			
Basic	54,126,545	51,509,366	50,198,954
Diluted	56,247,173	53,714,375	52,474,238

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

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CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF COMPREHENSIVE EARNINGS
(In thousands)

	Year Ended December 31,		
	2013	2012	2011
Net earnings (loss)	$165,718	$(11,295)	$108,363
Reclassification adjustment, net of tax	(875)	(1,789)	(549)
Change in unrealized (loss) gain on investments, net of tax	(6,934)	1,217	(114)
Other comprehensive earnings (loss)	(7,809)	(572)	(663)
Comprehensive earnings (loss)	157,909	(11,867)	107,700
Comprehensive earnings (loss) attributable to the noncontrolling interest	619	(13,154)	(2,855)
Comprehensive earnings attributable to Centene Corporation	$157,290	$1,287	$110,555

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

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CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(In thousands, except share data)

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Income	Retained Earnings	$.001 Par Value Shares	Amt	Non controlling Interest	Total
Balance, December 31, 2010	52,172,037	$52	$384,206	$6,424	$453,743	2,555,213	$(50,486)	$3,116	$797,055
Comprehensive Earnings:									
Net earnings	—	—	—	—	111,218	—	—	(2,855)	108,363
Change in unrealized investment gain, net of $(334) tax	—	—	—	(663)	—	—	—	—	(663)
Total comprehensive earnings									107,700
Common stock issued for employee benefit plans	1,414,689	2	15,435	—	—	—	—	—	15,437
Exercise of stock warrants	—	—	—	—	—	(50,000)	1,172	—	1,172
Common stock repurchases	—	—	—	—	—	216,895	(7,809)	—	(7,809)
Stock compensation expense	—	—	18,171	—	—	—	—	—	18,171
Excess tax benefits from stock compensation	—	—	4,169	—	—	—	—	—	4,169
Contributions from Noncontrolling interest	—	—	—	—	—	—	—	813	813
Deconsolidation of Noncontrolling interest	—	—	—	—	—	—	—	(289)	(289)
Balance, December 31, 2011	53,586,726	$54	$421,981	$5,761	$564,961	2,722,108	$(57,123)	$785	$936,419
Comprehensive Earnings:									

Net earnings (loss)	—	—	—	—	1,859	—	—	(13,154)	(11,295)
Change in unrealized investment gain, net of $(296) tax	—	—	—	(572)	—	—	—	—	(572)
Total comprehensive earnings (loss)									(11,867)
Common stock issued for employee benefit plans	1,752,434	1	16,725	—	—	—	—	—	16,726
Common stock repurchases	—	—	—	—	—	287,804	(12,741)	—	(12,741)
Stock compensation expense	—	—	25,332	—	—	—	—	—	25,332
Excess tax benefits from stock compensation	—	—	10,999	—	—	—	—	—	10,999
Purchase of noncontrolling interest	—	—	(24,181)	—	—	—	—	11,988	(12,193)
Contribution from noncontrolling interest	—	—	—	—	—	—	—	1,092	1,092
Balance, December 31, 2012	55,339,160	$55	$450,856	$5,189	$566,820	3,009,912	$(69,864)	$711	$953,767
Comprehensive Earnings:									
Net earnings (loss)	—	—	—	—	165,099	—	—	619	165,718
Change in unrealized investment loss, net of $(4,438) tax	—	—	—	(7,809)	—	—	—	—	(7,809)
Total comprehensive earnings									157,909
Common stock issued for acquisition	1,716,690	2	75,405	—	—	—	—	—	75,407
Common stock issued for stock offering	342,640	—	15,225	—	—	—	—	—	15,225
Common stock issued for employee benefit	1,274,725	2	9,796	—	—	—	—	—	9,798

plans									
Common stock repurchases	—	—	—	—	—	344,064	(19,779)	—	(19,779)
Stock compensation expense	—	—	36,656	—	—	—	—	—	36,656
Excess tax benefits from stock compensation	—	—	6,388	—	—	—	—	—	6,388
Contribution from noncontrolling interest	—	—	—	—	—	—	—	8,068	8,068
Balance, December 31, 2013	58,673,215	$59	$594,326	$(2,620)	$731,919	3,353,976	$(89,643)	$9,398	$1,243,439

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

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CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)

	Year Ended December 31, 2013	2012	2011
Cash flows from operating activities:			
Net earnings (loss)	$165,718	$(11,295)	$108,363
Adjustments to reconcile net earnings to net cash provided by operating activities			
Depreciation and amortization	67,420	65,866	58,327
Stock compensation expense	36,656	25,332	18,171
Impairment loss	—	28,033	
Gain on sale of investment in convertible note	—	(17,880)	—
Debt extinguishment costs	—	—	8,488
Deferred income taxes	(2,293)	(14,438)	2,031
Changes in assets and liabilities			
Premium and related receivables	(142,977)	(116,558)	(11,306)
Other current assets	(79,588)	(36,818)	(11,812)
Other assets	(736)	2,825	(2)
Medical claims liabilities	171,569	359,792	149,756
Unearned revenue	2,724	24,707	(109,082)
Accounts payable and accrued expenses	151,712	(21,474)	38,889
Other operating activities	12,321	(9,401)	9,873
Net cash provided by operating activities	382,526	278,691	261,696
Cash flows from investing activities:			
Capital expenditures	(67,835)	(82,144)	(73,708)
Purchases of investments	(790,653)	(695,687)	(318,397)
Sales and maturities of investments	579,161	589,921	267,404
Investments in acquisitions, net of cash acquired	(62,773)	—	(4,375)
Net cash used in investing activities	(342,100)	(187,910)	(129,076)
Cash flows from financing activities:			
Proceeds from exercise of stock options	8,983	15,912	15,815
Proceeds from borrowings	180,000	400,500	419,183
Proceeds from stock offering	15,225	—	—
Payment of long term debt	(41,593)	(218,234)	(416,283)
Excess tax benefits from stock compensation	6,380	10,996	4,435
Common stock repurchases	(19,779)	(12,741)	(7,809)
Contribution from noncontrolling interest	8,068	1,092	813
Purchase of noncontrolling interest	—	(14,429)	—
Debt issue costs	(3,589)	(3,623)	(9,242)
Net cash provided by financing activities	153,695	179,473	6,912
Net increase in cash and cash equivalents	194,121	270,254	139,532
Cash and cash equivalents, beginning of period	843,952	573,698	434,166
Cash and cash equivalents, end of period	$1,038,073	$843,952	$573,698
Supplemental disclosures of cash flow information:			
Interest paid	$30,009	$21,605	$27,383
Income taxes paid	$84,681	$42,877	$50,444
Equity issued in connection with acquisition	$75,425	$—	$—

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

CENTENE CORPORATION AND SUBSIDIARIES
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
(Dollars in thousands, except share data)

1. Organization and Operations

Centene Corporation, or the Company, is a diversified, multi-line healthcare enterprise operating in two segments: Managed Care and Specialty Services. The Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program, or CHIP, Long Term Care (LTC), Foster Care, Medicare Special Needs Plans and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program, or collectively ABD. The Specialty Services segment consists of our specialty companies offering auxiliary healthcare services and products to state programs, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries. The health plan in Massachusetts, operated by our individual health insurance business, is included in the Specialty Services segment.

2. Summary of Significant Accounting Policies

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of Centene Corporation and all majority owned subsidiaries and subsidiaries over which the Company exercises the power and control to direct activities significantly impacting financial performance. All material intercompany balances and transactions have been eliminated. The assets, liabilities and results of operations of Kentucky Spirit Health Plan are classified as discontinued operations for all periods presented.

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

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles in the United States, or GAAP, requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Future events and their effects cannot be predicted with certainty; accordingly, the accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of the consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained and as the operating environment changes. The Company evaluates and updates its assumptions and estimates on an ongoing basis and may employ outside experts to assist in our evaluation, as considered necessary. Actual results could differ from those estimates.

Cash and Cash Equivalents

Investments with original maturities of three months or less are considered to be cash equivalents. Cash equivalents consist of money market funds and bank certificates of deposit and savings accounts.

The Company maintains amounts on deposit with various financial institutions, which may exceed federally insured limits. However, management periodically evaluates the credit-worthiness of those institutions, and the Company has not experienced any losses on such deposits.

Investments

Short term investments include securities with maturities greater than three months to one year. Long term investments include securities with maturities greater than one year.

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Short term and long term investments are generally classified as available for sale and are carried at fair value. Certain equity investments are recorded using the cost or equity method. Unrealized gains and losses on investments available for sale are excluded from earnings and reported in accumulated other comprehensive income, a separate component of stockholders' equity, net of income tax effects. Premiums and discounts are amortized or accreted over the life of the related security using the effective interest method. The Company monitors the difference between the cost and fair value of investments. Investments that experience a decline in value that is judged to be other than temporary are written down to fair value and a realized loss is recorded in investment and other income. To calculate realized gains and losses on the sale of investments, the Company uses the specific amortized cost of each investment sold. Realized gains and losses are recorded in investment and other income.

The Company uses the equity method to account for certain of its investment in entities that it does not control and for which it does not have the ability to exercise significant influence over operating and financial policies. These investments are recorded at the lower of their cost or fair value.

Restricted Deposits

Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. These investments are classified as long term, regardless of the contractual maturity date, due to the nature of the states' requirements. The Company is required to annually adjust the amount of the deposit pledged to certain states.

Fair Value Measurements

In the normal course of business, the Company invests in various financial assets and incurs various financial liabilities. Fair values are disclosed for all financial instruments, whether or not such values are recognized in the Consolidated Balance Sheets. Management obtains quoted market prices and other observable inputs for these disclosures. The carrying amounts reported in the Consolidated Balance Sheets for cash and cash equivalents, premium and related receivables, unearned revenue, accounts payable and accrued expenses, and certain other current liabilities are carried at cost, which approximates fair value because of their short term nature.

The following methods and assumptions were used to estimate the fair value of each financial instrument:

- Available for sale investments and restricted deposits: The carrying amount is stated at fair value, based on quoted market prices, where available. For securities not actively traded, fair values were estimated using values obtained from independent pricing services or quoted market prices of comparable instruments.
- Senior unsecured notes: Estimated based on third-party quoted market prices for the same or similar issues.
- Variable rate debt: The carrying amount of our floating rate debt approximates fair value since the interest rates adjust based on market rate adjustments.
- Interest rate swap: Estimated based on third-party market prices based on the forward 3-month LIBOR curve.

Property, Software and Equipment

Property, software and equipment are stated at cost less accumulated depreciation. Capitalized software includes certain costs incurred in the development of internal-use software, including external direct costs of materials and services and payroll costs of employees devoted to specific software development. Depreciation is calculated principally by the straight-line method over estimated useful lives. Leasehold improvements are depreciated using the straight-line method over the shorter of the expected useful life or the remaining term of the lease. Property, software and equipment are depreciated over the following periods:

Fixed Asset	Depreciation Period
Buildings and land improvements	5 - 40 years

Computer hardware and software	2 - 7 years
Furniture and equipment	3 - 10 years
Leasehold improvements	1 - 20 years

The carrying amounts of all long-lived assets are evaluated to determine if adjustment to the depreciation and amortization period or to the unamortized balance is warranted. Such evaluation is based principally on the expected utilization of the long-lived assets.

The Company retains fully depreciated assets in property and accumulated depreciation accounts until it removes them from service. In the case of sale, retirement, or disposal, the asset cost and related accumulated depreciation balance is removed from the respective account, and the resulting net amount, less any proceeds, is included as a component of earnings from operations in the consolidated statements of operations.

Goodwill and Intangible Assets

Intangible assets represent assets acquired in purchase transactions and consist primarily of customer relationships, purchased contract rights, provider contracts, trade names and goodwill. Intangible assets are amortized using the straight-line method over the following periods:

Intangible Asset	Amortization Period
Purchased contract rights	5 - 15 years
Provider contracts	4 - 15 years
Customer relationships	5 - 15 years
Trade names	7 - 20 years

The Company tests for impairment of intangible assets as well as long-lived assets whenever events or changes in circumstances indicate that the carrying value of an asset or asset group (hereinafter referred to as “asset group”) may not be recoverable by comparing the sum of the estimated undiscounted future cash flows expected to result from use of the asset group and its eventual disposition to the carrying value. Such factors include, but are not limited to, significant changes in membership, state funding, state contracts and provider networks and contracts. If the sum of the estimated undiscounted future cash flows is less than the carrying value, an impairment determination is required. The amount of impairment is calculated by subtracting the fair value of the asset group from the carrying value of the asset group. An impairment charge, if any, is recognized within earnings from operations.

The Company tests goodwill for impairment using a fair value approach. The Company is required to test for impairment at least annually, absent a triggering event including a significant decline in operating performance that would require an impairment assessment. Absent any impairment indicators, the Company performs its goodwill impairment testing during the fourth quarter of each year. The Company recognizes an impairment charge for any amount by which the carrying amount of goodwill exceeds its implied fair value.

The Company first assesses qualitative factors to determine whether it is necessary to perform the two-step quantitative goodwill impairment test. The Company does not calculate the fair value of a reporting unit unless it determines, based on a qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount.

If the two-step quantitative test is deemed necessary, the Company uses discounted cash flows to establish the fair value as of the testing date. The discounted cash flow approach includes many assumptions related to future growth rates, discount factors, future tax rates, etc. Changes in economic and operating conditions impacting these assumptions could result in goodwill impairment in future periods. When available and as appropriate, the Company uses comparative market multiples to corroborate discounted cash flow results.

Medical Claims Liability

Medical claims liability includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. The Company estimates its medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Actuarial Standards of Practice generally require that the medical claims liability estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amounts ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. The Company includes in its IBNR an estimate for medical claims liability under moderately adverse conditions which represents the risk of adverse deviation of the estimates in its actuarial method of reserving.

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The Company uses its judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions it considers when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to fee schedules, and the incidence of high dollar or catastrophic claims.

The Company's development of the medical claims liability estimate is a continuous process which it monitors and refines on a monthly basis as additional claims receipts and payment information becomes available. As more complete claims information becomes available, the Company adjusts the amount of the estimates, and includes the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, the operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. The Company consistently applies its reserving methodology from period to period. As additional information becomes known, it adjusts the actuarial model accordingly to establish medical claims liability estimates.

The Company periodically reviews actual and anticipated experience compared to the assumptions used to establish medical costs. The Company establishes premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs.

Revenue Recognition

The Company's health plans generate revenues primarily from premiums received from the states in which it operates health plans. The Company receives a fixed premium per member per month pursuant to its state contracts. The Company generally receives premium payments during the month it provides services and recognizes premium revenue during the period in which it is obligated to provide services to its members. In some instances, the Company's base premiums are subject to an adjustment, or risk score, based on the acuity of its membership. Generally, the risk score is determined by the State analyzing submissions of processed claims data to determine the acuity of the Company's membership relative to the entire state's Medicaid membership. Some states enact premium taxes, similar assessments and provider pass-through payments, collectively premium taxes, and these taxes are recorded as a separate component of both revenues and operating expenses. Some contracts allow for additional premiums related to certain supplemental services provided such as maternity deliveries.

Revenues are recorded based on membership and eligibility data provided by the states, which is adjusted on a monthly basis by the states for retroactive additions or deletions to membership data. These eligibility adjustments are estimated monthly and subsequent adjustments are made in the period known. We continuously review and update those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

The Company's specialty companies generate revenues under contracts with state programs, individuals, healthcare organizations and other commercial organizations, as well as from the Company's own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of service.

Premium and Related Receivables and Unearned Revenue

Premium and service revenues collected in advance are recorded as unearned revenue. For performance-based contracts the Company does not recognize revenue subject to refund until data is sufficient to measure performance. Premiums and service revenues due to the Company are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and management's judgment on the collectibility of these accounts. As the Company generally receives payments during the month in which services are provided, the allowance is typically not significant in comparison to total revenues and does not have a material impact on the presentation of the financial condition or results of operations. Activity in the allowance for uncollectible accounts for the years ended December 31, is summarized below:

	2013	2012	2011
Allowances, beginning of year	781	639	17
Amounts charged to expense	3,138	1,350	865
Write-offs of uncollectible receivables	(2,801)	(1,208)	(243)
Allowances, end of year	1,118	781	639

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Significant Customers

Centene receives the majority of its revenues under contracts or subcontracts with state Medicaid managed care programs. The current contracts expire on various dates between March 31, 2014 and October 31, 2018. States whose aggregate annual contract value exceeded 10% of annual revenues and the respective percentage of the Company's total revenues for the years ended December 31, are as follows:

2013		2012		2011	
Texas	37%	Texas	40%	Georgia	15%
				Ohio	12%
				Texas	21%

Reinsurance

Centene's subsidiaries report reinsurance premiums as medical costs, while related reinsurance recoveries are reported as deductions from medical costs. The Company limits its risk of certain catastrophic losses by maintaining high deductible reinsurance coverage.

Other Income (Expense)

Other income (expense) consists principally of investment income, interest expense and equity method earnings from investments. Investment income is derived from the Company's cash, cash equivalents, restricted deposits and investments. Interest expense relates to borrowings under the senior notes, interest rate swap, credit facilities, interest on capital leases and credit facility fees.

Income Taxes

Deferred tax assets and liabilities are recorded for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax law or tax rates is recognized in income in the period that includes the enactment date.

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. In determining if a deductible temporary difference or net operating loss can be realized, the Company considers future reversals of existing taxable temporary differences, future taxable income, taxable income in prior carryback periods and tax planning strategies.

Contingencies

The Company accrues for loss contingencies associated with outstanding litigation, claims and assessments for which it has determined it is probable that a loss contingency exists and the amount of loss can be reasonably estimated. The Company expenses professional fees associated with litigation claims and assessments as incurred.

Stock Based Compensation

The fair value of the Company's employee share options and similar instruments are estimated using the Black-Scholes option-pricing model. That cost is recognized over the period during which an employee is required to provide service in exchange for the award. Excess tax benefits related to stock compensation are presented as a cash inflow from financing activities.

Recent Accounting Pronouncements

In 2011, the Financial Accounting Standards Board issued accounting guidance for the health insurance industry's annual fees mandated by the Patient Protection and Affordable Care Act. The fees will be imposed beginning in 2014 based on the Company's share of the industry's net premiums written during the preceding calendar year. In addition, these fees will not be tax deductible. Under the guidance, the liability for the fee will be estimated and recorded in full each year beginning in 2014

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when health insurance is first provided. A corresponding deferred cost will be recorded and amortized to operating expense over the calendar year.

3. Noncontrolling Interest and Acquisition

Noncontrolling Interest

The Company has consolidated subsidiaries where it maintains less than 100% ownership. The Company's ownership interest for each subsidiary as of December 31, are as follows:

	2013		2012		2011	
Casenet	100	%	100	%	81	%
Centurion	51	%	51	%	51	%
Louisiana Healthcare Connections	100	%	100	%	51	%
Home State Health Plan	95	%	95	%	—	%

Casenet. During 2011, the Company increased its ownership interest in Casenet to 81% and in December 2012, acquired the remaining ownership interest for $4,429. The excess purchase price over the noncontrolling interest was recorded to additional paid in capital, net of the related deferred tax asset. Casenet is recorded in the Specialty Services segment.

Centurion. During 2011, the Company began operations as a 51% joint venture partner with MHM Services Inc. as Centurion. In July 2013, Centurion began operating under a new contract with the Department of Corrections in Massachusetts to provide comprehensive healthcare services to individuals incarcerated in Massachusetts state correctional facilities and in September 2013, began operating under a new contract to provide comprehensive healthcare services to individuals incarcerated in Tennessee state correctional facilities. Centurion is recorded in the Specialty Services segment.

Home State Health Plan. In July 2012, the Company began operations as a 95% joint venture partner, operating under a new contract with the Office of Administration for Missouri to serve Medicaid beneficiaries in the Eastern, Central, and Western Managed Care Regions of the state.

Louisiana Healthcare Connections. In February 2012, the Company began operations under a new contract in Louisiana through a joint venture subsidiary, Louisiana Healthcare Connections. The Company initially owned a 51% interest in the subsidiary and in October 2012, acquired the remaining noncontrolling interest for $10,000. The purchase price in excess of the noncontrolling interest was recorded to additional paid in capital. The operating results of Louisiana are included in the Company's Managed Care segment.

Net income attributable to Centene Corporation and transfers from (to) noncontrolling interest entities are as follows:

	Year Ended December 31,		
	2013	2012	2011
Net earnings attributable to Centene Corporation	$161,218	$88,533	$120,518
Transfers from (to) the noncontrolling interest:			
Decrease in equity for purchase of, distribution to and redemption of noncontrolling interest	—	(12,193)	(289)
Increase in equity for distributions from and consolidation of noncontrolling interest	8,068	1,092	813
Net transfers from (to) noncontrolling interest	8,068	(11,101)	524
Changes from net earnings attributable to Centene Corporation and net transfers from (to) the noncontrolling interest	$169,286	$77,432	$121,042

Acquisition

AcariaHealth. In April 2013, the Company acquired 100% of AcariaHealth, a specialty pharmacy company, for $142,495 in total consideration. The transaction consideration was financed through a combination of $75,425 of Centene common stock and $67,070 of cash on hand. The Company also sold 342,640 shares of common stock for $15,225 related to funding the escrow account for the acquisition. The Company's allocation of fair value resulted in goodwill of $92,144 and other

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identifiable intangible assets of $35,000. The goodwill is not deductible for income tax purposes. The acquisition is recorded in the Specialty Services segment.

Pro forma disclosures related to the acquisitions have been excluded as immaterial.

4. Discontinued Operations: Kentucky Spirit Health Plan

In October 2012, the Company notified the Kentucky Cabinet for Health and Family Services (Cabinet) that it was exercising a contractual right that it believes allows the Company to terminate its Medicaid managed care contract with the Commonwealth of Kentucky (Commonwealth) effective July 5, 2013. As of July 6, 2013, our subsidiary, Kentucky Spirit Health Plan (KSHP), ceased serving Medicaid members in Kentucky. Accordingly, the results of operations of KSHP are presented as discontinued operations for all periods presented. The assets, liabilities and results of operations of KSHP are classified as discontinued operations for all periods presented beginning in 2011. KSHP was previously reported in the Managed Care segment.

During the years ended December 31, 2013 and 2012, the Company incurred exit costs consisting primarily of lease termination fees and employee severance. The change in exit cost liability for KSHP is summarized as follows:

	Employee Benefits	Lease Termination	Total
Balance, December 31, 2011	$—	$—	$—
Incurred	2,939	—	2,939
Balance, December 31, 2012	2,939	—	2,939
Incurred	434	735	1,169
Paid	(2,837)	—	(2,837)
Balance, December 31, 2013	$536	$735	$1,271

KSHP had remaining statutory capital of approximately $83,600 at December 31, 2013, which will be transferred to unregulated cash, subject to regulatory approval.

Operating results for the discontinued operations are as follows:

	Year Ended December 31,		
	2013	2012	2011
Revenues	$248,327	$557,316	$129,105
Earnings (loss) before income taxes	$6,165	$(134,415)	$(13,465)
Net earnings (loss)	$3,881	$(86,674)	$(9,300)

Assets and liabilities of the discontinued operations are as follows:

	December 31, 2013	December 31, 2012
Current assets	$77,512	$176,996
Long term investments and restricted deposits	38,305	60,461
Other assets	—	1,836
Assets of discontinued operations	$115,817	$239,293
Medical claims liability	$27,637	$111,141
Accounts payable and accrued expenses	2,657	45,975
Other liabilities	1,028	357
Liabilities of discontinued operations	$31,322	$157,473

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5. Short term and Long term Investments and Restricted Deposits

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

	December 31, 2013				December 31, 2012			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$246,085	$245	$(7,494)	$238,836	$110,941	$581	$(221)	$111,301
Corporate securities	293,912	2,782	(608)	296,086	290,691	4,615	(195)	295,111
Restricted certificates of deposit	5,891	—	—	5,891	5,890	—	—	5,890
Restricted cash equivalents	26,642	—	—	26,642	14,455	—	—	14,455
Municipal securities:								
General obligation	54,003	555	(136)	54,422	85,440	1,157	(26)	86,571
Pre-refunded	10,835	82	—	10,917	5,337	85	—	5,422
Revenue	68,801	545	(292)	69,054	82,781	1,313	(30)	84,064
Variable rate demand notes	28,575	—	—	28,575	23,385	—	—	23,385
Asset backed securities	138,803	579	(332)	139,050	73,570	1,082	(15)	74,637
Mortgage backed securities	33,974	—	(83)	33,891	—	—	—	—
Cost and equity method investments	22,239	—	—	22,239	11,298	—	—	11,298
Life insurance contracts	15,369	—	—	15,369	15,023	—	—	15,023
Total	$945,129	$4,788	$(8,945)	$940,972	$718,811	$8,833	$(487)	$727,157

The Company’s investments are classified as available-for-sale with the exception of life insurance contracts and certain cost and equity method investments. The Company’s investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets with the focus on high credit quality securities. The Company limits the size of investment in any single issuer other than U.S. treasury securities and obligations of U.S. government corporations and agencies. The Company's mortgage backed securities are issued by the Federal National Mortgage Association and carry guarantees by the U.S. government. As of December 31, 2013, 52% of the Company’s investments in securities recorded at fair value that carry a rating by S&P or Moody’s were rated AAA/Aaa, 68% were rated AA-/Aa3 or higher, and 94% were rated A-/A3 or higher. At December 31, 2013, the Company held certificates of deposit, life insurance contracts and cost and equity method investments which did not carry a credit rating.

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

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	December 31, 2013				December 31, 2012			
	Less Than 12 Months		12 Months or More		Less Than 12 Months		12 Months or More	
	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$(6,188)	$172,365	$(1,307)	$26,454	$(219)	$56,033	$(2)	$201
Corporate securities	(400)	52,725	(207)	5,020	(195)	44,208	—	—
Municipal securities:								
General obligation	(72)	3,480	(63)	2,426	(26)	7,930	—	—
Revenue	(292)	27,789	—	—	(30)	3,090	—	—
Asset backed securities	(333)	37,689	—	—	(15)	8,192	—	—
Mortgage backed securities	(83)	33,891	—	—	—	—	—	—
Total	$(7,368)	$327,939	$(1,577)	$33,900	$(485)	$119,453	$(2)	$201

As of December 31, 2013, the gross unrealized losses were generated from 83 positions out of a total of 343 positions. The decline in fair value of fixed income securities is a result of movement in interest rates subsequent to the purchase of the security.

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

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

	December 31, 2013				December 31, 2012			
	Investments		Restricted Deposits		Investments		Restricted Deposits	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value
One year or less	$101,537	$102,126	$40,633	$40,637	$136,997	$138,101	$33,897	$33,928
One year through five years	609,755	610,589	6,301	6,309	429,053	435,728	358	358
Five years through ten years	157,003	151,221	—	—	93,907	93,778	—	—
Greater than ten years	29,900	30,090	—	—	24,599	25,264	—	—
Total	$898,195	$894,026	$46,934	$46,946	$684,556	$692,871	$34,255	$34,286

Actual maturities may differ from contractual maturities due to call or prepayment options. Asset backed and mortgage backed securities are included in the one year through five years category, while cost and equity method investments and life insurance contracts are included in the five years through ten years category. The Company has an option to redeem at amortized cost substantially all of the securities included in the greater than ten years category listed above.

The Company continuously monitors investments for other-than-temporary impairment. Certain investments have experienced a decline in fair value due to changes in credit quality, market interest rates and/or general economic conditions. The Company recognizes an impairment loss for cost and equity method investments when evidence demonstrates that it is other-than-temporarily impaired. Evidence of a loss in value that is other than temporary may include the absence of an ability to recover the carrying amount of the investment or the inability of the investee to sustain a level of earnings that would justify the carrying amount of the investment.

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6. Fair Value Measurements

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

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

The following table summarizes fair value measurements by level at December 31, 2013, for assets and liabilities measured at fair value on a recurring basis:

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$974,304	$—	$—	$974,304
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$212,185	$12,238	$—	$224,423
Corporate securities	—	296,086	—	296,086
Municipal securities:				
General obligation	—	54,422	—	54,422
Pre-refunded	—	10,917	—	10,917
Revenue	—	69,054	—	69,054
Variable rate demand notes	—	28,575	—	28,575
Asset backed securities	—	139,050	—	139,050
Mortgage backed securities	$—	$33,891	$—	$33,891
Total investments	$212,185	$644,233	$—	$856,418
Restricted deposits available for sale:				
Cash and cash equivalents	$26,642	$—	$—	$26,642
Certificates of deposit	5,891	—	—	5,891
U.S. Treasury securities and obligations of U.S. government corporations and agencies	14,413	—	—	14,413
Total restricted deposits	$46,946	$—	$—	$46,946
Other long term assets:				
Interest rate swap contract	$—	$9,576	$—	$9,576
Total assets at fair value	$1,233,435	$653,809	$—	$1,887,244

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The following table summarizes fair value measurements by level at December 31, 2012, for assets and liabilities measured at fair value on a recurring basis:

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$745,933	$—	$—	$745,933
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$57,114	$40,246	$—	$97,360
Corporate securities	—	295,111	—	295,111
Municipal securities:				
General obligation	—	86,571	—	86,571
Pre-refunded	—	5,422	—	5,422
Revenue	—	84,064	—	84,064
Variable rate demand notes	—	23,385	—	23,385
Asset backed securities	—	74,637	—	74,637
Mortgage backed securities	—	—	—	—
Total investments	$57,114	$609,436	$—	$666,550
Restricted deposits available for sale:				
Cash and cash equivalents	$14,455	$—	$—	$14,455
Certificates of deposit	5,890	—	—	5,890
U.S. Treasury securities and obligations of U.S. government corporations and agencies	13,941	—	—	13,941
Total restricted deposits	$34,286	$—	$—	$34,286
Other long term assets:				
Interest rate swap contract	$—	$16,304	$—	$16,304
Total assets at fair value	$837,333	$625,740	$—	$1,463,073

The Company periodically transfers U.S. Treasury securities and obligations of U.S. government corporations and agencies between Level I and Level II fair value measurements dependent upon the level of trading activity for the specific securities at the measurement date. The Company's policy regarding the timing of transfers between Level I and Level II is to measure and record the transfers at the end of the reporting period. At December 31, 2013, there were $1,143 of transfers from Level I to Level II and $26,301 of transfers from Level II to Level I. The Company utilizes matrix pricing services to estimate fair value for securities which are not actively traded on the measurement date. The Company designates these securities as Level II fair value measurements. The aggregate carrying amount of the Company's life insurance contracts and other non-majority owned investments, which approximates fair value, was $37,608 and $26,321 as of December 31, 2013 and December 31, 2012, respectively.

7. Notes Receivable

Between July 2008 and October 2011, the Company made an investment of $30,000 in secured notes receivable to a third party as part of an investment in certain Medicaid and Medicare related businesses. The notes included a feature to convert the note balance into an equity ownership in the underlying businesses.

In September 2012, the Company executed an agreement with the borrower whereby the borrower agreed to pay the Company total consideration of $50,000 for retirement of the outstanding notes and equity ownership conversion feature. Under the terms of the agreement, the borrower paid the Company $30,000 in December 2012, and agreed to pay the Company $10,000 by September 30, 2013 and $10,000 by September 30, 2014. All outstanding balances are secured by liens on certain underlying businesses as well as guaranteed personally by the principal owner of the businesses. The $10,000 notes to be paid on or before September 30, 2013 and September 30, 2014 are non-interest bearing and, as a result, total consideration was discounted by $2,120 to reflect imputation of interest. As a result, during the third quarter of 2012, the Company recorded a pre-tax gain of $17,880 in other income representing the fair value of the total consideration in excess of the carrying value of the loans on the Company's balance sheet. As of December 31, 2013, the Company has a remaining receivable of $9,483 associated with this transaction.

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8. Property, Software and Equipment

Property, software and equipment consist of the following as of December 31:

	2013	2012
Computer software	$184,983	$164,755
Building	206,058	193,186
Land	69,705	70,276
Computer hardware	69,087	57,389
Furniture and office equipment	53,180	43,136
Leasehold improvements	56,816	49,808
	639,829	578,550
Less accumulated depreciation	(244,422)	(202,657)
Property, software and equipment, net	$395,407	$375,893

As of December 31, 2013 and 2012, the Company had assets acquired under capital leases included above of $5,815 and $6,133, net of accumulated amortization of $1,782 and $1,595, respectively. Amortization on assets under capital leases charged to expense is included in depreciation expense. Depreciation expense for the years ended December 31, 2013, 2012 and 2011 was $52,234, $48,942 and $42,098, respectively.

9. Goodwill and Intangible Assets

During the second quarter of 2012, the Company's subsidiary, Celtic Insurance Company, experienced a high level of medical costs for individual health policies, especially for recently issued policies related to members converted from another insurer during the first quarter of 2012. Additionally, in June 2012, the U.S. Supreme Court upheld the constitutionality of the Patient Protection and Affordable Care Act which limits the profitability of the individual health insurance business because of minimum medical loss ratios, guaranteed issue policies, and increased competition in the exchange market. As a result of these factors, the Company conducted an impairment analysis of the identifiable intangible assets and goodwill of the Celtic reporting unit. The impairment analysis resulted in goodwill and intangible asset impairments of $28,033, recorded as an impairment loss in the consolidated statement of operations. The impaired identifiable intangible assets of $2,340 and goodwill of $25,693 were reported under the Specialty Services segment; $26,589 of the impairment loss is not deductible for income tax purposes.

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

	Managed Care	Specialty Services	Total
Balance as of December 31, 2011	$151,402	$130,579	$281,981
Impairment	—	(25,693)	(25,693)
Balance as of December 31, 2012	151,402	104,886	256,288
Acquisition	—	92,144	92,144
Balance as of December 31, 2013	$151,402	$197,030	$348,432

Goodwill acquisitions and other adjustments were related to the acquisitions and finalization of fair value allocations discussed in Note 3, Noncontrolling Interest and Acquisitions.

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Intangible assets at December 31, consist of the following:

			Weighted Average Life in Years	
	2013	2012	2013	2012
Purchased contract rights	$21,988	$21,988	7.5	7.5
Provider contracts	35,537	2,737	13.2	9.8
Customer relationships	13,396	13,396	8.0	8.0
Trade names	8,695	6,495	18.9	16.3
Intangible assets	79,616	44,616	11.1	9.1
Less accumulated amortization:				
Purchased contract rights	(13,459)	(11,010)		
Provider contracts	(3,767)	(1,241)		
Customer relationships	(11,425)	(10,214)		
Trade names	(2,185)	(1,883)		
Total accumulated amortization	(30,836)	(24,348)		
Intangible assets, net	$48,780	$20,268		

Amortization expense was $6,489, $4,822 and $5,561 for the years ended December 31, 2013, 2012 and 2011 respectively. Estimated total amortization expense related to intangible assets for each of the five succeeding fiscal years is as follows:

Year	Expense
2014	$6,800
2015	5,900
2016	5,900
2017	4,400
2018	2,600

10. Medical Claims Liability

The change in medical claims liability is summarized as follows:

	Year Ended December 31,		
	2013	2012	2011
Balance, January 1,	$815,161	$518,840	$456,765
Incurred related to:			
Current year	9,072,867	6,836,177	4,256,645
Prior years	(78,226)	(55,096)	(65,377)
Total incurred	8,994,641	6,781,081	4,191,268
Paid related to:			
Current year	7,975,367	6,024,720	3,744,475
Prior years	722,726	460,040	384,718
Total paid	8,698,093	6,484,760	4,129,193
Balance, December 31,	$1,111,709	$815,161	$518,840

Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. In addition, claims processing initiatives yielded increased claim payment recoveries and coordination of benefits related to prior year dates of service. Changes in medical utilization and cost trends and the effect of medical management initiatives may also contribute to changes in medical claim liability estimates. While the Company has evidence that medical management initiatives are effective on a case by case basis, medical management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care, or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the medical management

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initiative are not known by the Company. Additionally, certain medical management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the medical management initiative changed the behavior cannot be determined. Because of the complexity of its business, the number of states in which it operates, and the volume of claims that it processes, the Company is unable to practically quantify the impact of these initiatives on its changes in estimates of IBNR.

The Company had reinsurance recoverables related to medical claims liability of $10,427 and $9,094 at December 31, 2013 and 2012, respectively, included in premium and related receivables.

The Company periodically reviews actual and anticipated experience compared to the assumptions used to establish medical costs. The Company establishes premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs.

11. Debt

Debt consists of the following:

	December 31, 2013	December 31, 2012
Senior notes, at par	$425,000	$425,000
Unamortized premium on senior notes	6,052	7,823
Interest rate swap fair value	9,576	16,304
Senior notes	440,628	449,127
Revolving credit agreement	150,000	—
Mortgage notes payable	72,785	84,081
Capital leases and other	5,349	5,646
Total debt	668,762	538,854
Less current portion	(3,065)	(3,373)
Long term debt	$665,697	$535,481

Senior Notes

In May 2011, the Company issued $250,000 non-callable 5.75% Senior Notes due June 1, 2017 (the $250,000 Notes) at a discount to yield 6%. In connection with the May 2011 issuance, the Company entered into an interest rate swap for a notional amount of $250,000. Gains and losses due to changes in the fair value of the interest rate swap completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $250,000 Notes. At December 31, 2013, the fair value of the interest rate swap increased the fair value of the notes by $9,576 and the variable interest rate of the swap was 3.74%.

In November 2012, the Company issued an additional $175,000 non-callable 5.75% Senior Notes due June 1, 2017 ($175,000 Add-on Notes) at a premium to yield 4.29%. The indenture governing the $250,000 Notes and the $175,000 Add-on Notes contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio. Interest is paid semi-annually in June and December. At December 31, 2013, the total net unamortized debt premium on the $250,000 Notes and $175,000 Add-on Notes was $6,052.

Revolving Credit Agreement

In May 2013, the Company entered into a new unsecured $500,000 revolving credit facility and terminated its previous $350,000 revolving credit facility. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement has a maturity date of June 1, 2018, provided it will mature 90 days prior to the maturity date of the Company's 5.75% Senior Notes due 2017 if such notes are not refinanced (or extended) or certain financial conditions are not met, including carrying $100,000 of unrestricted cash on deposit. As of December 31, 2013, the Company had $150,000 of borrowings outstanding under the agreement with a weighted average interest rate of 3.31%.

The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. The Company is required not to exceed a maximum debt-to-EBITDA ratio of 3.0 to 1.0. As of December 31, 2013, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

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Mortgage Notes Payable

The Company has a non-recourse mortgage note of $72,785 at December 31, 2013 collateralized by its corporate headquarters building. The mortgage note is due January 1, 2021 and bears a 5.14% interest rate. The collateralized property had a net book value of $160,246 at December 31, 2013.

The Company also had a mortgage note of $8,700 at December 31, 2012 collateralized by another building and parking garage. In June 2013, the Company repaid this mortgage note.

Letters of Credit & Surety Bonds

The Company had outstanding letters of credit of $28,757 as of December 31, 2013, which were not part of the revolving credit facility. The letters of credit bore interest at 0.51% as of December 31, 2013. The Company had outstanding surety bonds of $102,568 as of December 31, 2013.

Aggregate maturities for the Company's debt are as follows:

2014	$3,065
2015	3,188
2016	3,353
2017	428,525
2018	153,702
Thereafter	61,301
Total	$653,134

The fair value of outstanding debt was approximately $672,529 and $543,611 at December 31, 2013 and 2012, respectively.

12. Interest Rate Swap

In May 2011, the Company entered into $250,000 notional amount of interest rate swap agreements (Swap Agreements) that are scheduled to expire June 1, 2017. Under the Swap Agreements, the Company receives a fixed rate of 5.75% and pays a variable rate of the three month LIBOR plus 3.5% adjusted quarterly, which allows the Company to adjust $250,000 of its senior notes to a floating rate. The Company does not hold or issue any derivative instrument for trading or speculative purposes. At December 31, 2013, the variable rate was 3.74%.

The Swap Agreements are formally designated and qualify as fair value hedges. The Swap Agreements are recorded at fair value in the Consolidated Balance Sheet in other assets or other liabilities. Gains and losses due to changes in fair value of the interest rate swaps completely offset changes in the fair value of the hedged portion of the underlying debt. Therefore, no gain or loss has been recognized due to hedge ineffectiveness. Offsetting changes in fair value of both the interest rate swaps and the hedged portion of the underlying debt both were recognized in interest expense in the Consolidated Statement of Operations.

The fair value of the Swap Agreements as of December 31, 2013 was an asset of approximately $9,576, and is included in other long term assets in the Consolidated Balance Sheet. The fair value of the Swap Agreements excludes accrued interest and takes into consideration current interest rates and current likelihood of the swap counterparties' compliance with its contractual obligations.

13. Stockholders' Equity

The Company has 10,000,000 authorized shares of preferred stock at $.001 par value. At December 31, 2013, there were no preferred shares outstanding.

The Company's Board of Directors has authorized a stock repurchase program for up to 4,000,000 shares of the Company's common stock from time to time on the open market or through privately negotiated transactions. No duration has been placed on the repurchase program. The Company has 1,667,724 available shares remaining under the program for repurchases as of

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December 31, 2013. The Company reserves the right to discontinue the repurchase program at any time. During the year ended December 31, 2013, the Company did not repurchase any shares through this publicly announced program.

As a component of the employee stock compensation plan, employees can use shares of stock which have vested to satisfy minimum statutory tax withholding obligations. As part of this plan, the Company repurchased 344,064 shares at an aggregate cost of $19,779 in 2013 and 287,804 shares at an aggregate cost of $12,741 in 2012. These shares are included in the Company's treasury stock.

In April 2013, the Company completed the acquisition of AcariaHealth and as a result, issued 1,716,690 shares of Centene common stock to the selling stockholders. Additionally, the Company filed an equity shelf registration statement related to funding the escrow account for the acquisition and sold 342,640 shares of Centene common stock for $15,225.

14. Statutory Capital Requirements and Dividend Restrictions

Various state laws require Centene's regulated subsidiaries to maintain minimum capital levels specified by each state and restrict the amount of dividends that may be paid without prior regulatory approval. At December 31, 2013 and 2012, Centene's subsidiaries, including Kentucky Spirit Health Plan, had aggregate statutory capital and surplus of $1,279,700 and $990,300, respectively, compared with the required minimum aggregate statutory capital and surplus of $686,400 and $617,000, respectively.

15. Income Taxes

The consolidated income tax expense consists of the following for the years ended December 31:

	2013	2012	2011
Current provision:			
Federal	$120,858	$47,528	$63,388
State and local	5,857	(4,368)	5,157
Total current provision	126,715	43,160	68,545
Deferred provision	(19,635)	4,252	2,142
Total provision for income taxes	$107,080	$47,412	$70,687

The reconciliation of the tax provision at the U.S. Federal Statutory Rate to the provision for income taxes is as follows:

	2013	2012	2011
Earnings from continuing operations, before income tax expense	$268,917	$122,791	$188,350
Less flow through noncontrolling interest	960	(2,539)	(2,855)
Earnings from continuing operations, less noncontrolling interest, before income tax expense	267,957	125,330	191,205
Tax provision at the U.S. federal statutory rate	93,785	43,866	66,922
State income taxes, net of federal income tax benefit	2,871	(2,288)	3,381
Nondeductible goodwill impairment	—	8,487	—
Nondeductible compensation	12,519	1,108	2,705
Other, net	(2,095)	(3,761)	(2,321)
Income tax expense	$107,080	$47,412	$70,687

The tax effects of temporary differences which give rise to deferred tax assets and liabilities are presented below for the years ended December 31:

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	2013	2012
Deferred tax assets:		
Medical claims liability and other accruals	$53,943	$37,413
State net operating loss carry forward	9,530	9,055
Stock compensation	14,223	12,615
Other	30,199	20,573
Deferred tax assets	107,895	79,656
Valuation allowance	(8,119)	(8,180)
Net deferred tax assets	$99,776	$71,476
Deferred tax liabilities:		
Intangible assets	$18,278	$12,441
Prepaid assets	5,621	4,767
Depreciation and amortization	30,411	31,741
Other	1,615	5,624
Deferred tax liabilities	$55,925	$54,573
Net deferred tax assets	$43,851	$16,903

The Company's deferred tax assets include federal and state net operating losses, or NOLs, of which $6,547 were acquired in business combinations. Accordingly, the total and annual deduction for those NOLs is limited by tax law. The Company's federal NOLs expire between the years 2020 and 2032 and the state NOLs expire between the years 2014 and 2034. Valuation allowances are recorded for those NOLs the Company believes are more likely than not to expire unused. During 2013 and 2012, the Company recorded valuation allowance additions in the tax provision of $1,301 and $2,093, respectively. In 2013 and 2012, the Company recorded valuation allowance reductions of $1,362 and $2,289, respectively.

The Company maintains a reserve for uncertain tax positions that may be challenged by a tax authority. A roll-forward of the reserve is as follows:

	2013	2012
Gross unrecognized tax benefits, beginning of period	$7,870	$13,552
Gross increases:		
Current year tax positions	338	4,107
Prior year tax positions	164	451
Gross decreases:		
Prior year tax positions	—	(9,925)
Settlements	(4,390)	(53)
Statute of limitation lapses	(708)	(262)
Gross unrecognized tax benefits, end of period	$3,274	$7,870

Included in the balance of unrecognized tax benefits at December 31, 2013 and 2012 were reserve balances of $3,274 and $4,095, respectively, that, if recognized, would decrease the effective tax rate on income from continuing operations. Also included in the December 31, 2012 reserve balance were liabilities of $3,775 that, if recognized, would have been recorded as an adjustment to deferred taxes.

The Company recognizes interest accrued related to unrecognized tax benefits in the provision for income taxes. During the year ended December 31, 2013 and 2012, the Company recognized tax benefits generated from the net reduction in interest accrued of $310 and $170, respectively. Interest accrued, net of federal benefit, was $623, $933 and $1,157 as of December 31, 2013, 2012 and 2011, respectively. No penalties have been accrued.

During 2013, the IRS concluded its examination of the Company's 2010 and 2011 federal tax returns. The Company files in numerous state jurisdictions with varying statutes of limitation. The unrecognized state tax benefits are related to returns open from 2009 to 2013.

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16. Stock Incentive Plans

The Company's stock incentive plans allow for the granting of restricted stock or restricted stock unit awards and options to purchase common stock. Both incentive stock options and nonqualified stock options can be awarded under the plans. No option will be exercisable for longer than ten years after the date of grant. The plans have 1,414,240 shares available for future awards. Compensation expense for stock options and restricted stock unit awards is recognized on a straight-line basis over the vesting period, generally three to five years for stock options and 1 to 10 years for restricted stock or restricted stock unit awards. Certain restricted stock unit awards contain performance-based as well as service-based provisions. Certain awards provide for accelerated vesting if there is a change in control as defined in the plans. The total compensation cost that has been charged against income for the stock incentive plans was $36,153, $25,001 and $18,141 for the years ended December 31, 2013, 2012 and 2011, respectively. The total income tax benefit recognized in the income statement for stock-based compensation arrangements was $7,575, $8,952 and $5,804 for the years ended December 31, 2013, 2012 and 2011, respectively.

Option activity for the year ended December 31, 2013 is summarized below:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value	Weighted Average Remaining Contractual Term
Outstanding as of December 31, 2012	1,299,396	$22.39		
Granted	10,000	44.58		
Exercised	(361,538)	20.32		
Forfeited	(663)	17.86		
Outstanding as of December 31, 2013	947,195	$23.41	$33,659	2.8
Exercisable as of December 31, 2013	921,462	$23.21	$32,937	2.7

The fair value of each option grant is estimated on the date of the grant using the Black-Scholes option-pricing model with the following weighted-average assumptions:

	Year Ended December 31,		
	2013	2012 (1)	2011
Expected life (in years)	5.1	—	5.2
Risk-free interest rate	0.8%	—	0.9%
Expected volatility	48.1%	—	49.9%
Expected dividend yield	—	—	—

(1) No options were awarded in the year ended December 31, 2012.

For the years ended December 31, 2013, 2012 and 2011, the Company used a projected expected life for each award granted based on historical experience of employees' exercise behavior. The expected volatility is primarily based on historical volatility levels. The risk-free interest rates are based on the implied yield currently available on U.S. Treasury instruments with a remaining term equal to the expected life.

Other information pertaining to option activity is as follows:

	Year Ended December 31,		
	2013	2012 (1)	2011
Weighted-average fair value of options granted	$19.04	$—	$13.94
Total intrinsic value of stock options exercised	$12,845	$24,120	$11,744

(1) No options were awarded in the year ended December 31, 2012.

A summary of the Company's non-vested restricted stock and restricted stock unit shares as of December 31, 2013, and changes during the year ended December 31, 2013, is presented below:

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	Shares	Weighted Average Grant Date Fair Value
Non-vested balance as of December 31, 2012	2,058,908	$37.25
Granted	1,037,542	55.36
Vested	(961,741)	33.57
Forfeited	(45,116)	38.91
Non-vested balance as of December 31, 2013	2,089,593	$47.90

The total fair value of restricted stock and restricted stock units vested during the years ended December 31, 2013, 2012 and 2011, was $49,032, $38,576 and $22,280, respectively.

As of December 31, 2013, there was $87,901 of total unrecognized compensation cost related to non-vested share-based compensation arrangements granted under the plans; that cost is expected to be recognized over a weighted-average period of 1.7 years. The actual tax benefit realized for the tax deductions from disqualified dispositions of stock option exercises totaled $508, $1,078 and $955 for the years ended December 31, 2013, 2012 and 2011, respectively.

The Company maintains an employee stock purchase plan and has issued 42,084 shares, 47,613 shares, and 34,966 shares in 2013, 2012 and 2011, respectively.

17. Retirement Plan

Centene has a defined contribution plan which covers substantially all employees who are at least twenty-one years of age. Under the plan, eligible employees may contribute a percentage of their base salary, subject to certain limitations. Centene may elect to match a portion of the employee's contribution. Company expense related to matching contributions to the plan was $9,422, $6,771 and $5,119 during the years ended December 31, 2013, 2012 and 2011, respectively.

18. Commitments

Centene and its subsidiaries lease office facilities and various equipment under non-cancelable operating leases which may contain escalation provisions. The rental expense related to these leases is recorded on a straight-line basis over the lease term, including rent holidays. Tenant improvement allowances are recorded as a liability and amortized against rent expense over the term of the lease. Rent expense was $30,562, $27,564 and $22,537 for the years ended December 31, 2013, 2012 and 2011, respectively. Annual non-cancelable minimum lease payments over the next five years and thereafter are as follows:

2014	$25,350
2015	25,871
2016	24,202
2017	19,336
2018	12,628
Thereafter	18,800
	$126,187

19. Contingencies

In October 2012, the Company notified the Kentucky Cabinet for Health and Family Services (Cabinet) that it was exercising a contractual right that it believes allows the Company to terminate its Medicaid managed care contract with the Commonwealth of Kentucky (Commonwealth) effective July 5, 2013. The Company also filed a lawsuit in Franklin Circuit Court against the Commonwealth seeking a declaration of the Company's right to terminate the contract on July 5, 2013. In April 2013, the Commonwealth answered that lawsuit and filed counterclaims against the Company seeking declaratory relief and damages. In May 2013, the Franklin Circuit Court ruled that Kentucky Spirit does not have a contractual right to terminate the contract early. Kentucky Spirit has appealed that ruling to the Kentucky Court of Appeals.

The Company also filed a formal dispute with the Cabinet for damages incurred under the contract, which was later appealed to and denied by the Finance and Administration Cabinet. In response, the Company filed a lawsuit in April 2013, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches. This lawsuit was subsequently consolidated with the original lawsuit for declaratory relief and continues to proceed.

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Kentucky Spirit's efforts to resolve issues with the Commonwealth were unsuccessful and on July 5, 2013, Kentucky Spirit proceeded with its previously announced exit. The Commonwealth has alleged that Kentucky Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25,000 performance bond. Any claim for damages by the Commonwealth may include the costs of transition and the additional costs to the Commonwealth to cover Kentucky Spirit's former members through July 5, 2014. Kentucky Spirit is pursuing its litigation claims for damages against the Commonwealth and will vigorously defend against any allegations that it has breached the contract.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If the Company prevails on its claims, Kentucky Spirit would be entitled to damages under its lawsuit. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. The Company is unable to estimate the ultimate outcome resulting from the Kentucky litigation. As a result, the Company has not recorded any receivable or any liability for potential damages under the contract as of December 31, 2013. While uncertain, the ultimate resolution of the pending litigation could have a material effect on the financial position, cash flow or results of operations of the Company in the period it is resolved or becomes known.

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

20. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per common share for the years ended December 31:

	2013	2012	2011
Earnings attributable to Centene Corporation:			
Earnings from continuing operations, net of tax	$161,218	$88,533	$120,518
Discontinued operations, net of tax	3,881	(86,674)	(9,300)
Net earnings	$165,099	$1,859	$111,218
Shares used in computing per share amounts:			
Weighted average number of common shares outstanding	54,126,545	51,509,366	50,198,954
Common stock equivalents (as determined by applying the treasury stock method)	2,120,628	2,205,009	2,275,284
Weighted average number of common shares and potential dilutive common shares outstanding	56,247,173	53,714,375	52,474,238
Net earnings per common share attributable to Centene Corporation:			
Basic:			
Continuing operations	$2.98	$1.72	$2.40
Discontinued operations	0.07	(1.68)	(0.18)
Basic earnings per common share	$3.05	$0.04	$2.22
Diluted:			
Continuing operations	$2.87	$1.65	$2.30
Discontinued operations	0.07	(1.62)	(0.18)
Diluted earnings per common share	$2.94	$0.03	$2.12

The calculation of diluted earnings per common share for 2013, 2012 and 2011 excludes the impact of 93,539 shares, 142,425 shares and 106,219 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

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21. Segment Information

Centene operates in two segments: Managed Care and Specialty Services. The Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene's specialty companies offering auxiliary healthcare services and products. The health plan in Massachusetts, operated by our individual health insurance business, is included in the Specialty Services segment.

Factors used in determining the reportable business segments include the nature of operating activities, existence of separate senior management teams, and the type of information presented to the Company's chief operating decision maker to evaluate all results of operations.

In January 2013, the Company reclassified the health plan in Arizona, which is primarily a LTC operation, to the Managed Care segment. As a result, the financial results of the Arizona health plan have been reclassified from the Specialty Services segment to the Managed Care segment for all periods presented.

Segment information as of and for the year ended December 31, 2013, follows:

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$9,740,720	$785,320	$—	$10,526,040
Premium and service revenues from internal customers	41,094	2,147,200	(2,188,294)	—
Total premium and service revenues	9,781,814	2,932,520	(2,188,294)	10,526,040
Earnings from operations	197,844	79,573	—	277,417
Total assets	2,817,519	595,964	—	3,413,483

Segment information as of and for the year ended December 31, 2012, follows:

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$7,124,720	$556,911	$—	$7,681,631
Premium and service revenues from internal customers	87,319	1,550,096	(1,637,415)	—
Total premium and service revenues	7,212,039	2,107,007	(1,637,415)	7,681,631
Earnings from operations	62,867	45,099	—	107,966
Total assets	2,163,347	371,265	—	2,534,612

Segment information as of and for the year ended December 31, 2011, follows:

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$4,571,430	$480,472	$—	$5,051,902
Premium and service revenues from internal customers	64,809	710,002	(774,811)	—
Total premium and service revenues	4,636,239	1,190,474	(774,811)	5,051,902
Earnings from operations	161,890	41,913	—	203,803
Total assets	1,709,271	383,259	—	2,092,530

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22. Quarterly Selected Financial Information
(In thousands, except share data and membership data)
(Unaudited)

	For the Quarter Ended			
	March 31, 2013	June 30, 2013	September 30, 2013	December 31, 2013
Total revenues	$2,525,482	$2,610,538	$2,795,569	$2,931,740
Amounts attributable to Centene Corporation common shareholders:				
Earnings from continuing operations, net of income tax expense	$22,639	$40,289	$50,325	$47,965
Discontinued operations, net of income tax expense (benefit)	363	(805)	(952)	5,275
Net earnings	$23,002	$39,484	$49,373	$53,240
Net earnings (loss) per common share attributable to Centene Corporation:				
Basic:				
Continuing operations	$0.43	$0.74	$0.92	$0.87
Discontinued operations	0.01	(0.02)	(0.02)	0.10
Basic earnings per common share	$0.44	$0.72	$0.90	$0.97
Diluted:				
Continuing operations	$0.41	$0.71	$0.88	$0.84
Discontinued operations	0.01	0.01	(0.01)	0.09
Diluted earnings per common share	$0.42	$0.72	$0.87	$0.93
Health Benefits Ratio	90.2 %	88.4 %	87.8 %	88.1 %
General & Administrative Expense Ratio	8.4 %	8.9 %	9.1 %	8.9 %
Period end at-risk membership	2,553,400	2,563,400	2,612,500	2,723,200

	For the Quarter Ended			
	March 31, 2012	June 30, 2012	September 30, 2012	December 31, 2012
Total revenues	$1,562,809	$1,967,362	$2,308,075	$2,272,050
Amounts attributable to Centene Corporation common shareholders:				
Earnings (loss) from continuing operations, net of income tax expense (benefit)	$27,072	$(16,656)	$59,438	$18,679
Discontinued operations, net of income tax benefit	(3,094)	(18,343)	(55,619)	(9,618)
Net earnings (loss)	$23,978	$(34,999)	$3,819	$9,061
Net earnings (loss) per common share attributable to Centene Corporation:				
Basic:				
Continuing operations	$0.53	$(0.32)	$1.15	$0.36
Discontinued operations	(0.06)	(0.36)	(1.08)	(0.19)
Basic earnings per common share	$0.47	$(0.68)	$0.07	$0.17
Diluted:				
Continuing operations	$0.51	$(0.32)	$1.10	$0.35
Discontinued operations	(0.06)	(0.36)	(1.03)	(0.18)

Diluted earnings per common share	$0.45	$(0.68)	$0.07	$0.17
Health Benefits Ratio	87.1%	91.2%	88.7%	90.7%
General & Administrative Expense Ratio	10.4%	8.5%	8.4%	8.4%
Period end at-risk membership	2,003,800	2,254,000	2,357,600	2,424,500

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23. Condensed Financial Information of Registrant

Centene Corporation (Parent Company Only)
Condensed Balance Sheets
(In thousands, except share data)

	December 31, 2013	2012
ASSETS		
Current assets:		
Cash and cash equivalents	$2,740	$22,279
Short term investments, at fair value (amortized cost $6,000 and $6,500, respectively)	6,000	6,500
Other current assets	124,903	42,230
Total current assets	133,643	71,009
Long term investments, at fair value (amortized cost $8,070 and $1,356, respectively)	8,070	1,356
Investment in subsidiaries	1,667,258	1,298,648
Other long term assets	31,876	42,523
Total assets	$1,840,847	$1,413,536
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities	$4,460	$4,333
Long term debt	590,628	449,127
Other long term liabilities	2,320	6,309
Total liabilities	597,408	459,769
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; 58,673,215 issued and 55,319,239 outstanding at December 31, 2013, and 55,339,160 issued and 52,329,248 outstanding at December 31, 2012	59	55
Additional paid-in capital	594,326	450,856
Accumulated other comprehensive income:		
Unrealized gain (loss) on investments, net of tax	(2,620)	5,189
Retained earnings	731,919	566,820
Treasury stock, at cost (3,353,976 and 3,009,912 shares, respectively)	(89,643)	(69,864)
Total Centene stockholders' equity	1,234,041	953,056
Noncontrolling interest	9,398	711
Total stockholders' equity	1,243,439	953,767
Total liabilities and stockholders' equity	$1,840,847	$1,413,536

See notes to condensed financial information of registrant.

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Centene Corporation (Parent Company Only)
Condensed Statements of Operations
(In thousands, except share data)

	Year Ended December 31,		
	2013	2012	2011
Expenses:			
General and administrative expenses	$4,196	$4,090	$4,488
Other income (expense):			
Investment and other income	983	19,921	(8,790)
Interest expense	(22,623)	(15,757)	(15,494)
Earnings (loss) before income taxes	(25,836)	74	(28,772)
Income tax benefit	(15,191)	(9,668)	(12,825)
Net earnings (loss) before equity in subsidiaries	(10,645)	9,742	(15,947)
Equity in earnings from subsidiaries	171,863	78,791	136,465
Net earnings from continuing operations	$161,218	$88,533	$120,518
Net earnings per share from continuing operations:			
Basic earnings per common share	$2.98	$1.72	$2.40
Diluted earnings per common share	$2.87	$1.65	$2.30
Weighted average number of shares outstanding:			
Basic	54,126,545	51,509,366	50,198,954
Diluted	56,247,173	53,714,375	52,474,238

See notes to condensed financial information of registrant.

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Centene Corporation (Parent Company Only)
Condensed Statements of Cash Flows
(In thousands)

	Year Ended December 31,		
	2013	2012	2011
Cash flows from operating activities:			
Cash provided by operating activities	$302,242	$327,940	$72,754
Cash flows from investing activities:			
Net dividends from and capital contributions to subsidiaries	(417,734)	(539,575)	(50,581)
Purchase of investments	(12,518)	(7,320)	(21,915)
Sales and maturities of investments	10,252	30,000	11,111
Acquisitions	(67,070)	—	(1,773)
Net cash used in investing activities	(487,070)	(516,895)	(63,158)
Cash flows from financing activities:			
Proceeds from borrowings	180,000	400,500	419,183
Payment of long term debt	(30,000)	(215,000)	(413,644)
Proceeds from exercise of stock options	8,983	15,912	15,815
Proceeds from stock offering	15,225	—	—
Common stock repurchases	(19,779)	(12,741)	(7,809)
Debt issue costs	(3,589)	(3,623)	(9,242)
Contributions from noncontrolling interest	8,069	1,092	813
Purchase of noncontrolling interest	—	(14,429)	—
Excess tax benefits from stock compensation	6,380	10,996	4,435
Net cash provided by financing activities	165,289	182,707	9,551
Net increase (decrease) in cash and cash equivalents	(19,539)	(6,248)	19,147
Cash and cash equivalents, beginning of period	22,279	28,527	9,380
Cash and cash equivalents, end of period	$2,740	$22,279	$28,527

See notes to condensed financial information of registrant.

Notes to Condensed Financial Information of Registrant

Note A - Basis of Presentation and Significant Accounting Policies

The parent company only financial statements should be read in conjunction with Centene Corporation's audited consolidated financial statements and the notes to consolidated financial statements included in this Form 10-K.

The parent company's investment in subsidiaries is stated at cost plus equity in undistributed earnings of the subsidiaries. The parent company's share of net income of its unconsolidated subsidiaries is included in income using the equity method of accounting. Certain unrestricted subsidiaries receive monthly management fees from our restricted subsidiaries. The management and service fees received by our unrestricted subsidiaries are associated with all of the functions required to manage the restricted subsidiaries including but not limited to salaries and wages for all personnel, rent, utilities, medical management, provider contracting, compliance, member services, claims processing, information technology, cash management, finance and accounting, and other services. The management fees are based on a percentage of the restricted subsidiaries revenue.

Due to our centralized cash management function, all cash flows generated by our unrestricted subsidiaries, including management fees, are transferred to the parent company, primarily to repay borrowings on the parent company's revolving credit facility. The parent company may also utilize the cash flow to make acquisitions, fund capital contributions to subsidiaries and fund its operations. During the years ended December 31, 2013, 2012 and 2011, cash flows received by the

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parent from unrestricted subsidiaries was $312,887, $318,198, and $88,701 and was included in cash flows from operating activities.

Certain amounts presented in the parent company only financial statements are eliminated in the consolidated financial statements of Centene Corporation.

Note B - Dividends

During 2013, 2012 and 2011, the Registrant received dividends from its subsidiaries totaling $20,500, $29,000 and $69,100, respectively.

24. Subsequent Events

In January 2014, the Company acquired a majority interest in U.S. Medical Management, LLC, a management services organization and provider of in-home health services for high acuity populations, for approximately $200,000. The transaction consideration was financed through a combination of cash on hand and 2,243,217 shares of Centene common stock.

Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure

None.

Item 9A. Controls and Procedures.

Evaluation of Disclosure Controls and Procedures - Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, evaluated the effectiveness of our disclosure controls and procedures as of December 31, 2013. The term “disclosure controls and procedures,” as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act, means controls and other procedures of a company that are designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the company's management, including its principal executive and principal financial officers, as appropriate to allow timely decisions regarding required disclosure. Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving their objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Based on the evaluation of our disclosure controls and procedures as of December 31, 2013, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective at the reasonable assurance level.

Management's Report on Internal Control Over Financial Reporting - Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f) and 15d-15(f). Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in Internal Control - Integrated Framework (1992) issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on our evaluation under the framework in Internal Control - Integrated Framework (1992), our management concluded that our internal control over financial reporting was effective at the reasonable assurance level as of December 31, 2013. Our management's assessment of the effectiveness of our internal control over financial reporting as of December 31, 2013 has been audited by KPMG LLP, an independent registered public accounting firm, as stated in their report which is included herein.

Changes in Internal Control Over Financial Reporting - No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the year ended December 31, 2013 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

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Report of Independent Registered Public Accounting Firm
The Board of Directors and Stockholders
Centene Corporation:

We have audited Centene Corporation's internal control over financial reporting as of December 31, 2013, based on criteria established in Internal Control - Integrated Framework (1992) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Centene Corporation's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, Centene Corporation maintained, in all material respects, effective internal control over financial reporting as of December 31, 2013, based on criteria established in Internal Control - Integrated Framework (1992) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Centene Corporation and subsidiaries as of December 31, 2013 and 2012, and the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2013, and our report dated February 21, 2014 expressed an unqualified opinion on those consolidated financial statements.

/s/ KPMG LLP

St. Louis, Missouri
February 21, 2014

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Item 9B. Other Information

None.

PART III

Item 10. Directors, Executive Officers and Corporate Governance

(a) Directors of the Registrant

Information concerning our directors will appear in our Proxy Statement for our 2014 annual meeting of stockholders under "Proposal One: Election of Directors". This portion of the Proxy Statement is incorporated herein by reference.

(b) Executive Officers of the Registrant

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

Information concerning our executive officers' compliance with Section 16(a) of the Exchange Act will appear in our Proxy Statement for our 2014 annual meeting of stockholders under "Section 16(a) Beneficial Ownership Reporting Compliance." Information concerning our audit committee financial expert and identification of our audit committee will appear in our Proxy Statement for our 2014 annual meeting of stockholders under "Board of Directors Committees." Information concerning our code of ethics will appear in our Proxy Statement for our 2014 annual meeting of stockholders under "Corporate Governance and Risk Management." These portions of our Proxy Statement are incorporated herein by reference.

(c) Corporate Governance

Information concerning certain corporate governance matters will appear in our Proxy Statement for our 2014 annual meeting of stockholders under "Corporate Governance and Risk Management." These portions of our Proxy Statement are incorporated herein by reference.

Item 11. Executive Compensation

Information concerning executive compensation will appear in our Proxy Statement for our 2014 Annual Meeting of Stockholders under "Information About Executive Compensation." Information concerning Compensation Committee interlocks and insider participation will appear in the Proxy Statement for our 2014 Annual Meeting of Stockholders under "Compensation Committee Interlocks and Insider Participation." These portions of the Proxy Statement are incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

Information concerning the security ownership of certain beneficial owners and management and our equity compensation plans will appear in our Proxy Statement for our 2014 annual meeting of stockholders under "Information About Stock Ownership" and "Equity Compensation Plan Information." These portions of the Proxy Statement are incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions, and Director Independence

Information concerning director independence, certain relationships and related transactions will appear in our Proxy Statement for our 2014 annual meeting of stockholders under “Corporate Governance and Risk Management” and “Related Party Transactions.” These portions of our Proxy Statement are incorporated herein by reference.

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Item 14. Principal Accountant Fees and Services

Information concerning principal accountant fees and services will appear in our Proxy Statement for our 2014 annual meeting of stockholders under "Proposal Two: Ratification of Appointment of Independent Registered Public Accounting Firm." This portion of our Proxy Statement is incorporated herein by reference.

PART IV

Item 15. Exhibits and Financial Statement Schedules

(a) Financial Statements and Schedules

The following documents are filed under Item 8 of this report:

1. Financial Statements:

Report of Independent Registered Public Accounting Firm
Consolidated Balance Sheets as of December 31, 2013 and 2012
Consolidated Statements of Operations for the years ended December 31, 2013, 2012 and 2011
Consolidated Statements of Comprehensive Earnings for the years ended December 31, 2013, 2012 and 2011
Consolidated Statements of Stockholders' Equity for the years ended December 31, 2013, 2012 and 2011
Consolidated Statements of Cash Flows for the years ended December 31, 2013, 2012 and 2011
Notes to Consolidated Financial Statements

2. Financial Statement Schedules:

None.

3. The exhibits listed in the accompanying Exhibit Index are filed or incorporated by reference as part of this filing.

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EXHIBIT INDEX

			INCORPORATED BY REFERENCE [1]		
EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
3.1	Certificate of Incorporation of Centene Corporation		S-1	October 9, 2001	3.2
3.1a	Certificate of Amendment to Certificate of Incorporation of Centene Corporation, dated November 8, 2001		S-1/A	November 13, 2001	3.2a
3.1b	Certificate of Amendment to Certificate of Incorporation of Centene Corporation as filed with the Secretary of State of the State of Delaware		10-Q	July 26, 2004	3.1b
3.2	By-laws of Centene Corporation, as amended effective as of February 3, 2014		8-K	February 6, 2014	3.1
4.1	Indenture, dated May 27, 2011, among the Company and The Bank of New York Mellon Trust Company, N.A., relating to the Company's 5.75% Senior Notes due 2017 (including Form of Global Note as Exhibit A thereto)		8-K	May 27, 2011	4.1
10.1 *	1996 Stock Plan of Centene Corporation, shares which are registered on Form S-8 - File Number 333-83190		S-1	October 9, 2001	10.9
10.2 *	1998 Stock Plan of Centene Corporation, shares which are registered on Form S-8 - File number 333-83190		S-1	October 9, 2001	10.10
10.3 *	1999 Stock Plan of Centene Corporation, shares which are registered on Form S-8 - File Number 333-83190		S-1	October 9, 2001	10.11
10.4 *	2000 Stock Plan of Centene Corporation, shares which are registered on Form S-8 - File Number 333-83190		S-1	October 9, 2001	10.12
10.5 *	2002 Employee Stock Purchase Plan of Centene Corporation, shares which are registered on Form S-8 - File Number 333-90976		10-Q	April 29, 2002	10.5

10.5a	*	First Amendment to the 2002 Employee Stock Purchase Plan	10-K	February 24, 2005	10.9a
10.5b	*	Second Amendment to the 2002 Employee Stock Purchase Plan	10-K	February 24, 2006	10.10b
10.6	*	Centene Corporation Amended and Restated 2003 Stock Incentive Plan, shares which are registered on Form S-8 - File Number 333-108467	8-K	April 30, 2010	10.1
10.7	*	2012 Stock Plan of Centene Corporation, shares which are registered on Form S-8 - File Number 333-180976	DEF 14A	March 9, 2012	4
10.8	*	Centene Corporation Non-Employee Directors Deferred Stock Compensation Plan	10-Q	October 25, 2004	10.1
10.8a	*	First Amendment to the Non-Employee Directors Deferred Stock Compensation Plan	10-K	February 24, 2006	10.12a
10.9	*	Centene Corporation Employee Deferred Compensation Plan	10-K	February 22, 2010	10.10
10.10	*	Centene Corporation 2007 Long Term Incentive Plan	8-K	April 26, 2007	10.2

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10.11	*	Centene Corporation Short Term Executive Compensation Plan	10-K	February 22, 2011	10.12
10.12	*	Executive Employment Agreement between Centene Corporation and Michael F. Neidorff, dated November 8, 2004	8-K	November 9, 2004	10.1
10.12a	*	Amendment No. 1 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff	10-Q	October 28, 2008	10.2
10.12b	*	Amendment No. 2 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff	10-Q	April 28, 2009	10.2
10.12c	*	Amendment No. 3 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff	10-Q	October 23, 2012	10.2
10.12d	*	Amendment No. 4 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff	8-K	May 16, 2013	10.1
10.13	*	Form of Executive Severance and Change in Control Agreement	10-Q	October 28, 2008	10.3
10.13a	*	Amendment No. 1 to Form of Executive Severance and Change in Control Agreement	10-Q	October 23, 2012	10.3
10.14	*	Form of Restricted Stock Unit Agreement	10-Q	October 28, 2008	10.4
10.15	*	Form of Non-statutory Stock Option Agreement (Non-Employees)	8-K	July 28, 2005	10.3
10.16	*	Form of Non-statutory Stock Option Agreement (Employees)	10-Q	October 28, 2008	10.5
10.17	*	Form of Non-statutory Stock Option Agreement (Directors)	10-K	February 23, 2009	10.18
10.18	*	Form of Incentive Stock Option Agreement	10-Q	October 28, 2008	10.6
10.19	*	Form of Stock Appreciation Right Agreement	8-K	July 28, 2005	10.6
10.20	*	Form of Restricted Stock Agreement	10-Q	October 25, 2005	10.8
10.21	*	Form of Performance Based Restricted Stock Unit Agreement #1	10-Q	October 28, 2008	10.7

10.22	*	Form of Performance Based Restricted Stock Unit Agreement #2	10-K	February 23, 2009	10.23
10.23	*	Form of Long Term Incentive Plan Agreement	8-K	February 7, 2008	10.1
10.24		Credit Agreement dated as of May 21, 2013 among Centene Corporation, the various financial institutions party hereto and Barclays Bank PLC	8-K	May 22, 2013	10.1
10.25	**	Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.	10-Q	October 25, 2011	10.2
10.25a	**	Amendment A (Version 2.1) to Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.	10-Q	April 24, 2012	10.1
10.25b	**	Amendment B (Version 2.2) to Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.	10-Q	July 24, 2012	10.1

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10.25c	**	Amendment C (Version 2.3) to Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.		10-Q	October 23, 2012	10.1
10.25d	**	Amendment D (Version 2.4) to Contract between the Texas Health and Human Services Commission and Bankers Life Insurance Company of Wisconsin, Inc. d.b.a Superior HealthPlan Network		10-Q	April 23, 2013	10.1
10.25e	**	Amendment E (Version 2.5) to Contract between the Texas Health and Human Services Commission and Bankers Life Insurance Company of Wisconsin, Inc. d.b.a Superior HealthPlan Network		10-Q	July 23, 2013	10.1
10.25f	**	Amendment F (Version 2.6) to Contract between the Texas Health and Human Services Commission and Bankers Life Insurance Company of Wisconsin, Inc. d.b.a Superior HealthPlan Network		10-Q	October 22, 2013	10.1
10.25g	**	Amendment G (Version 2.7) to Contract between the Texas Health and Human Services Commission and Bankers Life Insurance Company of Wisconsin, Inc. d.b.a Superior HealthPlan Network		10-Q	October 22, 2013	10.2
10.25h	**	Amendment H (Version 2.8) to Contract between the Texas Health and Human Services Commission and Bankers Life Insurance Company of Wisconsin, Inc. d.b.a Superior HealthPlan Network	X			
10.25i	**	Amendment I (Version 2.9) to Contract between the Texas Health and Human Services Commission and Bankers Life Insurance Company of Wisconsin, Inc. d.b.a Superior HealthPlan Network	X			
12.1		Computation of ratio of earnings to fixed charges	X			
21		List of subsidiaries	X			
23		Consent of Independent Registered Public Accounting Firm incorporated by reference in each prospectus constituting part of the Registration Statements on Form S-3 (File Numbers 333 174164, 333-187652, 333-187741,	X			

	and 333-193205) and on Form S-8 (File Numbers 333 108467, 333 90976, 333 83190, and 333 180976)	
31.1	Certification Pursuant to Rule 13a-14(a) and 15d-14(a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Executive Officer)	X
31.2	Certification Pursuant to Rule 13a-14(a) and 15d-14(a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Financial Officer)	X
32.1	Certification Pursuant to 18 U.S.C. Section 1350 (Chief Executive Officer)	X
32.2	Certification Pursuant to 18 U.S.C. Section 1350 (Chief Financial Officer)	X
101.1	XBRL Taxonomy Instance Document.	X
101.2	XBRL Taxonomy Extension Schema Document.	X
101.3	XBRL Taxonomy Extension Calculation Linkbase Document.	X

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101.4	XBRL Taxonomy Extension Definition Linkbase Document.	X
101.5	XBRL Taxonomy Extension Label Linkbase Document.	X
101.6	XBRL Taxonomy Extension Presentation Linkbase Document.	X

[1] SEC File No. 001-31826 (for filings prior to October 14, 2003, the Registrant's SEC File No. was 000-33395).
* Indicates a management contract or compensatory plan or arrangement.
** The Company has requested confidential treatment of the redacted portions of this exhibit pursuant to Rule 24b-2 under the Securities Exchange Act of 1934, as amended, and has separately filed a complete copy of this exhibit with the Securities and Exchange Commission.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, as of February 21, 2014.

CENTENE CORPORATION

By: /s/ Michael F. Neidorff
Michael F. Neidorff
Chairman and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities as indicated, as of February 21, 2014.

Signature	Title
/s/ Michael F. Neidorff Michael F. Neidorff	Chairman and Chief Executive Officer (principal executive officer)
/s/ William N. Scheffel William N. Scheffel	Executive Vice President and Chief Financial Officer (principal financial officer)
/s/ Jeffrey A. Schwaneke Jeffrey A. Schwaneke	Senior Vice President, Corporate Controller and Chief Accounting Officer (principal accounting officer)
/s/ Orlando Ayala Orlando Ayala	Director
/s/ Robert K. Ditmore Robert K. Ditmore	Director
/s/ Fred H. Eppinger Fred H. Eppinger	Director
/s/ Richard A. Gephardt Richard A. Gephardt	Director
/s/ Pamela A. Joseph Pamela A. Joseph	Director
/s/ John R. Roberts John R. Roberts	Director
/s/ David L. Steward David L. Steward	Director
/s/ Tommy G. Thompson Tommy G. Thompson	Director

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