WELLCARE HEALTH PLANS, INC.
Form 10-Q
March 02, 2009

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

(Mark One)

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

For the quarterly period ended September 30, 2008

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: 001-32209

WELLCARE HEALTH PLANS, INC.

(Exact name of registrant as specified in its charter)

Delaware	**47-0937650**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
8725 Henderson Road, Renaissance One Tampa, Florida	**33634**
(Address of principal executive offices)	(Zip Code)

(813) 290-6200

(Registrant s telephone number, including area code)

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.

Yes o No þ

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of large accelerated filer, accelerated filer and smaller reporting company in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer	Accelerated filer	Non-accelerated filer o	Smaller reporting company o
þ	o	(Do not check if a smaller reporting company)	

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).

Yes o No þ

As of February 28, 2009, there were 42,235,237 shares of the registrant s common stock, par value $.01 per share, outstanding.

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Explanatory Note

As previously disclosed, on October 24, 2007, certain federal and state agencies executed a search warrant at our headquarters in Tampa, Florida. Our Board of Directors (the Board) formed a special committee (the Special Committee) comprised of independent directors to, among other things, investigate independently and otherwise assess the facts and circumstances raised in any federal or state regulatory or enforcement inquiries (including, without limitation, any matters relating to accounting and operational issues) and in any private party proceedings, and develop and recommend remedial measures to the Board for its consideration. The Special Committee and the Company are cooperating fully with federal and state regulators and enforcement officials in these matters. The Special Committee s review is ongoing and we cannot provide assurances as to when it will be completed. Based on the issues referred to date to the Special Committee, other than as described in our Annual Report on Form 10-K for the fiscal year ended December 31, 2007 (the 2007 10-K), we currently do not believe that the work of the Special Committee will result in any material adjustments to the accompanying financial statements.

Upon consideration of certain issues identified in the Special Committee investigation and after discussions with management and our independent registered public accounting firm, the Audit Committee of the Board (the Audit Committee) recommended to the Board, and the Board thereafter concluded, that we should restate our previously issued consolidated financial statements for the years ended December 31, 2004, 2005 and 2006, including the quarterly periods contained therein, and the three-month period ended March 31, 2007 and the three- and six-month periods ended June 30, 2007, which were included in the 2007 10-K that we filed with the U.S. Securities and Exchange Commission (the SEC) on January 26, 2009.

The filing of this Quarterly Report on Form 10-Q was delayed due to, among other things, the delay in completing and filing our 2007 10-K. For additional information regarding these matters, please refer to our 2007 10-K.

References to the Company, WellCare, we, our, and us in this Quarterly Report on Form 10-Q refer to WellC Health Plans, Inc., together, in each case, with our subsidiaries and any predecessor entities unless the context suggests otherwise.

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Part I FINANCIAL INFORMATION

Item 1. Financial Statements.

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

	September 30, 2008	December 31, 2007
Assets		
Current Assets:		
Cash and cash equivalents	$ 1,176,283	$ 1,008,409
Investments	77,290	253,881
Premium and other receivables, net	234,440	307,513
Other receivables from government partners, net	5,825	2,464
Prepaid expenses and other current assets, net	124,348	112,246
Income taxes receivable	19,174	6,429
Deferred income taxes	35,880	
Total current assets	1,673,240	1,690,942
Property, equipment and capitalized software, net	65,618	66,560
Goodwill	189,470	189,470
Other intangible assets, net	14,876	16,286
Long term investments	56,031	
Restricted investment assets	199,863	89,236
Other assets	41,437	30,237
Total Assets	$ 2,240,535	$ 2,082,731
Liabilities and Stockholders Equity		
Current Liabilities:		
Medical benefits payable	$ 769,576	$ 538,146
Unearned premiums	513	19,838
Accounts payable	8,901	7,979
Other accrued expenses	339,757	324,116
Other payables to government partners	18,029	119,013
Deferred income taxes		5,985
Debt	153,501	154,581
Funds held for the benefit of members	38,876	31,782
Other current liabilities	674	556
Total current liabilities	1,329,827	1,201,996
Deferred income taxes	37,770	
Other liabilities	47,032	72,844
Total liabilities	1,414,629	1,274,840
Commitments and contingencies (see Note 7)		
Stockholders Equity:		

Preferred stock, $0.01 par value (20,000,000 authorized, no shares issued or outstanding)		
Common stock, $0.01 par value (100,000,000 authorized, 42,304,844 and 41,912,236 shares issued and outstanding at September 30, 2008 and December 31, 2007, respectively)	423	419
Paid-in capital	381,136	352,030
Retained earnings	449,730	455,474
Accumulated other comprehensive loss	(5,383)	(32)
Total stockholders equity	825,906	807,891
Total Liabilities and Stockholders Equity	$ 2,240,535	$ 2,082,731

See notes to unaudited condensed consolidated financial statements.

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2008	2007	2008	2007
Revenues:				
Premium	$ 1,629,306	$ 1,328,465	$ 4,886,699	$ 3,924,981
Investment and other income	8,126	29,961	33,072	66,819
Total revenues	1,637,432	1,358,426	4,919,771	3,991,800
Expenses:				
Medical benefits	1,443,742	972,880	4,218,254	3,136,999
Selling, general and administrative	228,811	216,146	690,330	543,461
Depreciation and amortization	5,385	4,924	15,763	13,742
Interest	2,962	3,418	9,170	10,317
Total expenses	1,680,900	1,197,368	4,933,517	3,704,519
Income before income taxes	(43,468)	161,058	(13,746)	287,281
Income tax (benefit) expense	(25,299)	81,712	(8,002)	130,282
Net (loss) income	$ (18,169)	$ 79,346	$ (5,744)	$ 156,999
Net (loss) income per common share (see Note 1):				
Net (loss) income per common share basic	$ (0.44)	$ 1.94	$ (0.14)	$ 3.87
Net (loss) income per common share diluted	$ (0.44)	$ 1.88	$ (0.14)	$ 3.74

See notes to unaudited condensed consolidated financial statements.

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

	Nine Months Ended September 30,	
	2008	**2007**
Cash from (used in) operating activities:		
Net (loss) income	$ (5,744)	$ 156,999
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization expense	15,764	13,742
Loss on disposal of fixed assets		21
Equity-based compensation expense	28,309	17,804
Incremental tax benefit received for from stock-based compensation	(2,162)	(22,607)
Deferred taxes, net	(4,095)	(19,942)
Changes in operating accounts:		
Premium and other receivables, net	73,073	(51,104)
Other receivables from government partners, net	(3,361)	27,123
Prepaid expenses and other, net	(12,102)	(12,096)
Medical benefits payable	231,430	75,634
Other payables to government partners	(100,984)	4,115
Unearned premiums	(19,325)	34,041
Accounts payable and other accrued expenses	16,563	59,947
Taxes, net	(10,583)	85,094
Other, net	(36,774)	(1,235)
Net cash provided by operations	170,009	367,536
Cash from (used in) investing activities:		
Proceeds from sale and maturities of investments	273,156	37,239
Purchases of investments	(157,947)	(197,072)
Purchases of restricted investments	(119,572)	(35,726)
Proceeds from sale and maturities of restricted investments	8,945	2,540
Additions to property and equipment, net	(13,412)	(13,788)
Net cash used in investing activities	(8,830)	(206,807)
Cash from (used in) financing activities:		
Proceeds from option exercises and other	1,039	17,186
Purchase of treasury stock	(2,400)	(4,417)
Incremental tax benefit received from stock-based compensation	2,162	22,607
Repayments on debt	(1,200)	(1,200)
Funds received for the benefits of members, net of disbursements	7,094	43,965
Net cash provided by financing activities	6,695	78,141
Cash and cash equivalents:		
Increase during year	167,874	238,870

Balance at beginning of year	1,008,409	964,542
Balance at end of year	$ 1,176,283	$ 1,203,412
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION:		
Cash paid for taxes	$ 44,223	$ 64,998
Cash paid for interest	$ 8,001	$ 9,292

See notes to unaudited condensed consolidated financial statements

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

1. ORGANIZATION AND BASIS OF PRESENTATION

WellCare Health Plans, Inc., a Delaware corporation (the Company or WellCare), provides managed care services exclusively to government-sponsored health care programs, focusing on Medicaid and Medicare, including health plans for families, children, the aged, blind and disabled and prescription drug plans, serving approximately 2,530,000 members nationwide as of September 30, 2008. The Company s Medicaid plans include plans for individuals who are dually eligible for both Medicare and Medicaid, recipients of the Temporary Assistance to Needy Families program (TANF), Supplemental Security Income program (SSI), State Children s Health Insurance Program (S-CHIP) and the Family Health Plus program (FHP). Through its licensed subsidiaries, as of September 30, 2008 the Company operated its Medicaid health plans in Florida, Georgia, Illinois, Missouri, New York and Ohio. The Company s Medicare plans include stand-alone prescription drug plans (PDP) and Medicare Advantage plans, which include both Medicare coordinated care (MCC) plans and Medicare private fee-for-service (PFFS) plans. As of September 30, 2008, the Company offered its MCC plans in Connecticut, Florida, Georgia, Illinois, Indiana, Louisiana, Missouri, New Jersey, New York, Ohio, and Texas and its PDP plans in all 50 states and the District of Columbia its PFFS plans in 43 states and the District of Columbia.

Basis of Presentation

The accompanying unaudited condensed consolidated interim financial statements should be read in conjunction with the consolidated financial statements and notes thereto for the fiscal year ended December 31, 2007 included in the 2007 10-K, filed with the SEC in January, 2009. In the opinion of the Company s management, the interim financial statements reflect all normal recurring adjustments that the Company considers necessary for the fair presentation of the financial position and results of operations and cash flows for the interim periods presented. The interim financial statements included herein have been prepared in accordance with accounting principles generally accepted in the United States of America (GAAP) and with the instructions to Form 10-Q and Article 10 of Regulation S-X. Accordingly, certain information and footnote disclosures normally included in financial statements prepared in accordance with GAAP have been condensed or omitted. Results for the interim periods presented are not necessarily indicative of results that may be expected for the entire year or any other interim period.

Certain 2007 amounts in the condensed consolidated interim financial statements have been condensed or reclassified to conform to the 2008 presentation.

Net (Loss) Income per Share

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2008	2007	2008	2007
Numerator:				
Net (loss) income basic and diluted (in thousands)	$ (18,169)	$ 79,346	$ (5,744)	$ 156,999
Denominator:				
Weighted-average common shares outstanding basic	41,538,055	40,969,300	41,321,526	40,575,572
Dilutive effect of:				
Unvested restricted common shares		380,044		421,312

Stock options			870,359		946,638
Weighted-average common shares outstanding diluted		41,538,055	42,219,703	41,321,526	41,943,522
Net (loss) income per common share:					
Net (loss) income per common share	basic	$ (0.44)	$ 1.94	$ (0.14)	$ 3.87
Net (loss) income per common share	diluted	$ (0.44)	$ 1.88	$ (0.14)	$ 3.74

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited, in thousands, except member and share data)

Certain options to purchase common stock were not included in weighted-average common shares outstanding diluted and therefore are not included in the calculation of diluted net income per common share because their exercise prices were greater than the average market price of the Company s common stock for the period and, therefore, the effect would be anti-dilutive. Due to the net loss for the three- and nine-month periods ended September 30, 2008, the assumed exercise of 5,692,115 equity awards had an antidilutive effect and are therefore excluded from the computation of diluted loss per share. For the three- and nine-month periods ended September 30, 2007, approximately 6,700 shares with an exercise price of $105.37 and 108,200 shares with exercise prices ranging from $90.05 to $105.37 per share were excluded from diluted weighted-average common shares outstanding, respectively.

Recently Adopted Accounting Standards

In September 2006, the Financial Accounting Standards Board (FASB) issued Statement of Financial Accounting Standard (FAS) No. 157, *Fair Value Measurements* (FAS 157). FAS 157 defines fair value, establishes a framework for measuring fair value in GAAP and requires enhanced disclosures about fair value measurements. FAS 157 does not require any new fair value measurements. The pronouncement is effective for fiscal years beginning after November 15, 2007. In February 2008, the FASB issued FASB Staff Position FAS 157-2, *Effective Date of FASB Statement No. 157* (FSP 157-2). FSP 157-2 delayed the effective date of FAS 157 for all non-financial assets and liabilities for one year, except those that are measured at fair value in the financial statements on at least an annual basis. The Company adopted FAS 157 as of January 1, 2008, except for those provisions deferred under FSP 157-2. The deferred provisions of FAS 157, which apply primarily to goodwill and other intangible assets for annual impairment testing purposes, will be effective in 2009. The Company adopted the new standard during the first quarter of 2008 as required. There was no cumulative effect of adopting FAS 157 for 2008.

In February 2007, the FASB issued Statement of Financial Accounting Standards No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities* (FAS 159). FAS 159 permits an entity to measure certain financial assets and financial liabilities at fair value. Under FAS 159, entities that elect the fair value option will report unrealized gains and losses in earnings at each subsequent reporting date. The pronouncement is effective for fiscal years beginning after November 15, 2007. The Company adopted the new standard during the first quarter of 2008 as required. There was no cumulative effect of adopting FAS 159 for 2008.

Recently Issued Accounting Standards

In April 2008, the FASB issued FASB Staff Position FAS 142-3, *Determination of the Useful Life of Intangible Assets* (FSP 142-3). FSP 142-3 amends the factors to be considered in developing renewal and extension assumptions used to determine the useful life of a recognized intangible asset accounted for under FAS No. 142, *Goodwill and Other Intangible Assets*. FSP 142-3 is effective for the Company s fiscal year 2009 and must be applied prospectively to intangible assets acquired after January 1, 2009. Early adoption is not permitted. The Company does not expect the adoption of FSP 142-3 will have a material impact on its Consolidated Financial Statements.

In March 2008, the FASB issued FAS No. 161, *Disclosures about Derivative Instruments and Hedging Activities* an amendment of FASB Statement No. 133 (FAS 161). FAS 161 amends and expands the disclosure requirements of FAS No. 133, *Accounting for Derivative Instruments and Hedging Activities* (FAS 133), to require qualitative disclosure about objectives and strategies for using derivatives; quantitative disclosures about fair value amounts and gains and losses on derivative instruments; and disclosures about credit-risk-related contingent features in derivative agreements. FAS 161 is effective for financial statements issued for fiscal years and interim periods beginning after November 15, 2008. The Company does not expect that the adoption of FAS 160 will have an impact on its Consolidated Financial Statements.

In December 2007, the FASB issued FAS No. 141 (revised 2008), *Business Combinations* (FAS 141R). FAS 141R replaces current guidance in FAS 141 to better represent the economic value of a business combination transaction. FAS 141 establishes principles and requirements for how an acquiring entity recognizes and measures all identifiable assets acquired, liabilities assumed, any non-controlling interest in the acquired entity and the goodwill acquired. The changes to be effected with FAS 141R from the current guidance include, but are not limited to treatment of certain

specific items such as expensing transaction and restructuring costs and adjusting earnings in periods subsequent to the acquisition for changes in deferred tax asset valuation allowances and income tax uncertainties as well as changes in the fair value of acquired contingent liabilities. FAS 141R also includes a substantial number of new disclosure requirements that will enable users of financial statements to evaluate the nature and financial effect of business combination. FAS 141R must be applied

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prospectively to all new acquisitions closing on or after January 1, 2009. The impact of this pronouncement will depend on future acquisition activity of the Company, if any.

In December 2007, the FASB issued FAS No. 160, *Noncontrolling Interests in Consolidated Financial Statements An Amendment of ARB No. 51* (FAS 160). FAS 160 requires that accounting and reporting for minority interests be recharacterized as noncontrolling interests and classified as a component of equity. The standard is effective for fiscal year 2009 and must be applied prospectively. The Company does not expect that the adoption of FAS 160 will have an impact on its consolidated financial statements.

2. SEGMENT REPORTING

The Company has two reportable segments: Medicaid and Medicare. The segments were determined based upon the type of governmental administration and funding of the health plans.

The Company s Medicaid segment includes plans for individuals who are dually eligible for both Medicare and Medicaid, and beneficiaries of TANF, SSI, S-CHIP and FHP. TANF generally provides assistance to low-income families with children and SSI generally provides assistance to low-income aged, blind or disabled individuals. The Company s Medicaid segment also includes other programs which are not part of the Medicaid program, such as S-CHIP and FHP for qualifying families who are not eligible for Medicaid because they exceed the applicable income thresholds.

The Company s Medicare segment includes stand-alone PDP and Medicare Advantage plans, which includes CCP, PFFS and PPO plans.

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2008	2007	2008	2007
Medicaid premium revenue	$ 771,035	$ 670,951	$ 2,252,681	$ 1,953,784
Medicare premium revenue	858,271	657,514	2,634,018	1,971,197
Total premium revenue:	1,629,306	1,328,465	4,886,699	3,924,981
Other income	8,126	29,961	33,072	66,819
Total revenues:	1,637,432	1,358,426	4,919,771	3,991,800
Medicaid medical benefits expense:	686,885	492,134	1,919,549	1,567,734
Medicare medical benefits expense:	756,857	480,746	2,298,705	1,569,265
Total Medical benefits expense:	1,443,742	972,880	4,218,254	3,136,999
Other expenses	237,158	224,488	715,263	567,520
Total expenses	1,680,900	1,197,368	4,933,517	3,704,519
Income(loss) before income taxes:	$ (43,468)	$ 161,058	$ (13,746)	$ 287,281

3. EQUITY-BASED COMPENSATION

The compensation expense recorded related to our equity-based compensation awards for the three months ended September 30, 2008 and 2007 was $10,440 and $5,917, respectively, and $28,309 and $17,804 for the nine months ended September 30, 2008 and 2007, respectively. During the three months ended September 30, 2008, the Company granted options for the purchase of 315,000 shares of common stock at a weighted-average exercise price of $36.23

per share and a weighted-average Black-Scholes fair value of $15.47 per share. During the nine months ended September 30, 2008, the Company granted options for the purchase of 3,094,298 shares of common stock at a weighted-average exercise price of $43.33 per share and a weighted-average Black-Scholes fair value of $16.51 per share. At September 30, 2008, options for 4,433,378 shares were outstanding with a weighted-average exercise price of $43.52 per share. There were no options exercised during the three-month period ended September 30, 2008. The total intrinsic value, determined as of the date of exercise, of options exercised during the three months ended September 30, 2007 was $9,674, and $4,057 and $51,575 for the nine months ended September 30, 2008 and 2007, respectively. During the three- and nine-month periods ended September 30, 2008, respectively, the Company granted 125,000 and 993,900 restricted shares and restricted share units at a weighted-average grant-date fair value of $36.79 and $42.94, respectively. At September 30, 2008, 1,258,737 share awards remained

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unvested. The total fair value of restricted shares awards vested during the three months ended September 30, 2008 and 2007 was $5,099 and $795, respectively, and $13,046 and $6,512 for the nine-months ended September 30, 2008 and 2007, respectively.

As of September 30, 2008, there was $85,595 of unrecognized compensation costs related to non-vested equity-based compensation arrangements that is expected to be recognized over a weighted-average period of 2.8 years.

4. FAIR VALUE OF FINANCIAL INSTRUMENTS

The Company s Consolidated Balance Sheets include the following financial instruments: cash and cash equivalents, receivables, investments, accounts payable, medical benefits payable and notes payable. The carrying amounts of current assets and liabilities approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization. The carrying value of the Company s term loan approximates its fair value due to the loan being in default and, as a result, the lender has the ability to accelerate the payment of the remaining amounts due from the Company, which amounts are equal to the term loan carrying amounts. Additionally, because the term of the agreement expires on May 13, 2009, the carrying amount of the term loan approximates its fair value due to the relatively short period of time between September 30, 2008 and the expiration of the term loan agreement.

The Company adopted FAS 157 for its financial assets and financial liabilities as of January 1, 2008. This standard defines fair value, establishes a framework for measuring fair value and expands disclosures about fair value measurements. The fair value hierarchy is as follows:

Level 1 Quoted (unadjusted) prices for identical assets or liabilities in active markets.

Level 2 Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or

indirectly, including:

Quoted prices for similar assets/liabilities in active markets;

Quoted prices for identical or similar assets in non-active markets (few transactions, limited information, non-current prices, high variability over time);

Inputs other than quoted prices that are observable for the asset/liability (e.g., interest rates, yield curves, volatilities, default rates, etc.); and

Inputs that are derived principally from or corroborated by other observable market data.

Level 3 Unobservable inputs that cannot be corroborated by observable market data.

As of September 30, 2008, $56,031 of the Company s investments were comprised of municipal note investments with an auction reset feature (auction rate securities). These notes carry investment grade ratings and are issued by various state and local municipal entities for the purpose of financing student loans, public projects and other activities. Liquidity for these auction rate securities is typically provided by an auction process which allows holders to sell their notes and resets the applicable interest rate at pre-determined intervals, usually every seven, 14, 28 or 35 days. The Company s auction rate securities are designated as available-for-sale securities and are reflected at fair value. The fair values of these securities were estimated using discounted cash flow analysis as of September 30, 2008. These analyses considered, among other things, the collateralization underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would be expected to have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties. Prior to January 1, 2008, these securities were recorded at fair value based on quoted prices in active markets (i.e., FAS 157 Level 1 data).

As of December 31, 2007, the Company had $204,700 in auction rate securities, of which $5,400 and $143,300 were settled at par during the three- and nine-month periods ended September 30, 2008 respectively. The remaining

auction rate securities at September 30, 2008 had auctions that failed during the three- and nine-months ended September 30, 2008. An auction failure means that the parties wishing to sell their securities could not be matched with an adequate volume of buyers. In the event that there is a failed auction the indenture governing the security requires the issuer to pay interest at a contractually defined rate that is generally above market rates for other types of similar short-term instruments. The securities for which auctions have

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited, in thousands, except member and share data)

failed continue to accrue interest at the contractual rate and be auctioned every seven, 14, 28 or 35 days until the auction succeeds, the issuer calls the securities, or they mature. As a result, the Company s ability to liquidate and fully recover the carrying value of its remaining auction rate securities in the near term may be limited or non-existent. The final maturity of the underlying auction rate securities could be as long as 33 years with a weighted-average life of 22 years for Company s auction rate securities portfolio. The Company does not believe its auction rate securities are impaired, primarily due to government guarantees or municipal bond insurance securities and, as a result, the Company did not record any impairment losses for its auction rate securities as of September 30, 2008. At December 31, 2008, the Company had $54,972 of auction rate securities and has the ability and the present intent to hold the securities until market stability is restored.

The Company s assets measured at fair value on a recurring basis subject to the disclosure requirements of SFAS 157 were as follows:

		Fair Value Measurements at September 30, 2008 Using:		
Description	**September 30, 2008**	**Quoted Prices in Active Markets for Identical Assets (Level 1)**	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**
Investments:				
Available-for-sale securities				
Certificates of deposit	$ 69,465	$ 69,465	$	$
Auction rate securities	56,031			56,031
Variable rate demand notes	3,900	3,900		
Other municipal variable rate bonds	3,925	3,925		
Total investments	$ 133,321	$ 77,290	$	$ 56,031
Restricted investments				
Available-for-sale				
Cash	$ 5,889	$ 5,889	$	$
Certificates of deposit	1,709	1,709		
U.S. Government securities	19,726	19,726		
Money market funds	172,539	172,539		
Total restricted investments	$ 199,863	$ 199,863	$	$

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

Certificates of Deposit. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months.

Auction Rate Securities. All auction rate securities are held as available-for-sale investments. The fair values of these securities were estimated using discounted cash flow analysis as of September 30, 2008. These analyses considered,

among other things, the collateralization underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would be expected to have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties. The fair values use an approach that relies heavily on management assumptions and qualitative observations and are therefore considered to be Level 3 fair values.

Other municipal variable rate bonds. The estimated fair values of U.S. Government securities held as available-for-sale are based on quoted market prices and/or other market data for the same or comparable instruments and transactions in establishing the prices.

Cash and Cash Equivalents. The carrying value of cash and cash equivalents approximates fair value as maturities are less than three months.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited, in thousands, except member and share data)

U.S. Government Securities. The estimated fair values of U.S. Government securities held as available-for-sale are based on quoted market prices and/or other market data for the same or comparable instruments and transactions in establishing the prices.

Money Market Funds. The carrying value of money market funds approximates fair value as maturities are less than three months.

The following table presents our auction rate securities measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in SFAS 157:

	Fair Value Measurements Using Significant Unobservable Inputs (Level 3)	
	Three months ended September 30, 2008	Nine months ended September 30, 2008
Beginning balance	$ 63,030	$
Total gains or losses (realized or unrealized)		
Included in earnings (or changes in net assets)		
Included in other comprehensive income	(1,549)	(5,368)
Purchases, issuances and settlements	(5,450)	(52,475)
Transfers in and/or out of Level 3		113,874
Ending balance at September 30, 2008	$ 56,031	$ 56,031

As a result of the declines in fair value for our investments in auction rate securities, which the Company deems to be temporary and attributable to liquidity issues rather than to credit issues, the Company recorded a net unrealized loss of $1,549 and $5,368 to Accumulated other comprehensive income in the three- and nine-month periods ended September 30, 2008, respectively. If the Company determines that any future valuation adjustment was other than temporary, a charge to earnings would be recorded as appropriate.

5. INCOME TAXES

The Company uses the asset and liability method of accounting for income taxes. As of September 30, 2008 and 2007, net deferred tax assets were approximately $35,736 and $9,065, respectively. For the period ending September 30, 2008 and 2007, $37,626 and $61,106, respectively, of the net deferred tax assets are included in other assets. In assessing the realizability of deferred tax assets, management considers the scheduled reversal of deferred tax liabilities, projected future taxable income and tax planning strategies. The Company expects the deferred tax assets to be realized through the generation of future taxable income and the reversal of existing taxable temporary differences.

The Company adopted FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes (FIN 48),* on January 1, 2007. There was no cumulative effect of adopting FIN 48 for 2007. The total amount of unrecognized tax benefits as of the date of adoption was $1,093. The amount of unrecognized tax benefits as of September 30, 2008 and 2007 is $38,719 and $62,199, respectively.

The Company classifies interest and penalties associated with uncertain income tax positions as income taxes within its Condensed Consolidated Financial Statements. The FIN 48 liability is recorded in Other liabilities. During the nine-month period ended September 30, 2008, the Company recognized $1,066 in interest expense that is included in the current tax expense for 2008. No amount was accrued for penalties. As of September 30, 2008 and 2007, the

total amount of unrecognized tax benefits that, if recognized, would affect the effective tax rate was $1,093.

The Company currently files income tax returns in the U.S. federal jurisdiction and various states. The Internal Revenue Service is currently completing its exams on the consolidated income tax returns for the 2004 through 2006 tax years. The Company is no longer subject to income tax examinations prior to 2004 in major state jurisdictions. The Company does not believe any adjustments that may result from these examinations will be significant.

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The Company believes it is reasonably possible that its liability for unrecognized tax benefits will not significantly increase or decrease in the next twelve months as a result of audit settlements and the expiration of statutes of limitations in certain major jurisdictions.

6. DEBT

Credit Agreement

The Company and certain of its subsidiaries are parties to a credit agreement, dated as of May 13, 2004, which was subsequently amended in September 2005, September 2006, and January 2008 (as amended, the Credit Agreement).

As of September 30, 2008, the credit facilities under the Credit Agreement consisted of a senior secured term loan facility in the outstanding principal amount of approximately $153,501, which matures in May 2009. The term loan and revolving credit facilities were secured by a pledge of substantially all of the assets or our non-regulated entities, which includes the stock of our operating subsidiaries directly held by our non-regulated entities. Interest is payable quarterly, currently at a rate equal to the sum of a rate based upon the Prime rate plus a rate equal to 1.50%. The Company is a party to this agreement for the purpose of guaranteeing the indebtedness of its subsidiaries that are parties to the agreement. The revolving credit facility had not been utilized before its expiration.

The Credit Agreement contains various restrictive covenants which limit, among other things, the Company s ability to incur indebtedness and liens, enter into business combination transactions and cause its regulated subsidiaries to declare and pay dividends to the Company or its non-regulated subsidiaries. As a result of the on-going investigations discussed in Note 7, the Company has been unable to satisfy a number of its obligations under the Credit Agreement, including providing audited financial statements, annual financial plans, and other information sought by the lenders under the Credit Agreement. Consequently, since November 2007 the Company has been in technical default under the terms of this Credit Agreement. In addition, as of September 30, 2008, the Company was in default of certain covenants set forth in the Credit Agreement requiring the Company to maintain certain leverage ratios. The Company continues to make payments as required, and consequently, there has been no payment default under the terms of the Credit Agreement. As of the date of this Quarterly Report on Form 10-Q, the Company s direct financial obligations under the Credit Agreement have not been accelerated or increased; however, the lenders have the right to do so at any time.

7. COMMITMENTS AND CONTINGENCIES

Government Investigations

The Company is currently under investigation by several federal and state authorities, including the Florida Agency for Health Care Administration (AHCA), the U.S. Attorney s Office for the Middle District of Florida (the USAO), the Civil Division of the U.S. Department of Justice (the Civil Division), the Office of Inspector General of the U.S. Department of Health and Human Services (the OIG) and the Florida Attorney General s Medicaid Fraud Control Unit (MFCU). Pursuant to an agreement dated August 18, 2008 with AHCA, the USAO and MFCU, two of the Company s subsidiaries, WellCare of Florida, Inc. and HealthEase of Florida, Inc. (collectively, the WellCare Florida HMOs), agreed to transmit $35,200 (the Transmitted Amount) to the Financial Litigation Unit of the USAO. The Transmitted Amount was based upon the Company s best estimate, as of the effective date of the agreement, of the total potential amount of Medicaid behavioral health capitation refunds that the WellCare Florida HMOs owe or may owe to AHCA for calendar years 2002 through 2006, but did not include any interest, fines, penalties or other assessments that may be imposed against the Company. Of the total Transmitted Amount, the Company acknowledged and agreed that the WellCare Florida HMOs would make payment of not less than a total amount of $24,500, and therefore the Company authorized the USAO, AHCA and MFCU to access and distribute the $24,500 to the appropriate federal and state agencies in accordance with applicable federal and state law. In addition, the parties to the agreement acknowledged and agreed that $10,700 of the Transmitted Amount would be held in an escrow account pending resolution of all federal and related state claims by the United States or the State of Florida for monetary damages or other financial impositions of any kind arising from, or related to, the investigation by MFCU or the USAO. The amount held in escrow does not limit in any way the ability of federal or state authorities to recover additional amounts, including interest, civil or criminal fines, penalties or other assessments that may be imposed against the Company, nor does it provide any assurances that the federal or state authorities will not seek or be entitled to recover amounts in excess of the escrowed amounts. The agreement did not, nor should it be construed to, operate as a settlement or release of any

criminal, civil or administrative claims for monetary, injunctive or other relief against the Company, whether under federal, state or local statutes, regulations or common law. Furthermore, the agreement does not operate, nor should it be construed, as a concession that the Company is entitled to any limitation of its potential federal, state or local civil or criminal liability.

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The Company is engaged in resolution discussions as to matters under review with the USAO, the Civil Division, the OIG and the State of Florida. Based on the current status of matters and all information known to the Company to date, a liability in the amount of $50,000 has been recorded in the Company s financial statements in connection with the ultimate resolution of these matters. However, the Company cannot provide assurances regarding the likelihood, timing or terms and conditions of any potential negotiated resolution of pending investigations by the USAO, the Civil Division, the OIG or the State of Florida.

In addition to the federal and state governmental investigations referenced above, as previously disclosed, the SEC is conducting an informal investigation. The Company also is responding to subpoenas issued by the State of Connecticut Attorney General s Office involving transactions between the Company and its affiliates and their potential impact on the costs of Connecticut s Medicaid program. The Company has communicated with regulators in states in which the Company s HMO and insurance operating subsidiaries are domiciled regarding the investigations. The Company is cooperating with federal and state regulators and enforcement officials in these matters. The Company does not know whether, or the extent to which, any pending investigations might lead to the payment of fines, penalties or the imposition of operating restrictions on its business.

In addition, in a letter dated October 15, 2008, the Civil Division informed counsel to the Special Committee that as part of the pending civil inquiry, the Civil Division is investigating a number of *qui tam* complaints filed by relators against the Company under the whistleblower provisions of the False Claims Act, 31 U.S.C. sections 3729-3733. The seal in those cases has been partially lifted for the purpose of authorizing the Civil Division to disclose to the Company the existence of the *qui tam* complaints. The complaints otherwise remain under seal as required by 31 U.S.C. section 3730(b)(3). The Company and the Special Committee are undertaking to discuss with the Civil Division, and address, allegations by the *qui tam* relators.

The Company also learned from a docket search that a former employee filed a *qui tam* action on October 25, 2007 in state court for Leon County, Florida against several defendants, including the Company and one of its subsidiaries. Because *qui tam* actions brought under federal and state false claims acts are sealed by the court at the time of filing, the Company is unable to determine the nature of the allegations and, therefore, the Company does not know at this time whether this action relates to the subject matter of the federal investigations. It is possible that additional *qui tam* actions have been filed against the Company and are under seal. Thus, it is possible that the Company is subject to liability exposure under the False Claims Act, or similar state statutes, based on *qui tam* actions other than those discussed in this Quarterly Report on Form 10-Q.

Class Action and Derivative Lawsuits

Putative class action complaints were filed on October 26, 2007 and on November 2, 2007. These putative class actions, entitled Eastwood Enterprises, L.L.C. v. Farha, et al. and Hutton v. WellCare Health Plans, Inc. et al., respectively, were filed in the United States District Court for the Middle District of Florida against the Company, Todd Farha, the Company s former chairman and chief executive officer, and Paul Behrens, the Company s former senior vice president and chief financial officer. Messrs. Farha and Behrens were also officers of various subsidiaries of the Company. The Eastwood Enterprises complaint alleges that the defendants materially misstated the Company s reported financial condition by, among other things, purportedly overstating revenue and understating expenses in amounts unspecified in the pleading in violation of the Securities Exchange Act of 1934, as amended. The Hutton complaint alleges that various public statements supposedly issued by defendants were materially misleading because they failed to disclose that the Company was purportedly operating its business in a potentially illegal and improper manner in violation of applicable federal guidelines and regulations. The complaint asserts claims under the Securities Exchange Act of 1934, as amended. Both complaints seek, among other things, certification as a class action and damages. The two actions were consolidated, and various parties and law firms filed motions seeking to be designated as Lead Plaintiff and Lead Counsel. In an Order issued on March 11, 2008, the Court appointed a group of five public pension funds from New Mexico, Louisiana and Chicago (the Public Pension Fund Group) as Lead Plaintiffs. On October 31, 2008, an amended consolidated complaint was filed in this class action against the Company, Messrs. Farha and Behrens, and adding Thaddeus Bereday, the Company s former senior vice president and general counsel, as a defendant. On January 23, 2009, the Company and certain other defendants filed a joint motion to dismiss the amended consolidated complaint, arguing, among other things, that the complaint failed to allege a

material misstatement by defendants with respect to the Company s compliance with marketing and other health care regulations and failed to plead facts raising a strong inference of scienter with respect to all aspects of the purported fraud claim. The Company intends to defend itself vigorously against these claims. At this time, neither the Company nor

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any of its subsidiaries can predict the probable outcome of these claims. Accordingly, no amounts have been accrued in the Company s condensed consolidated financial statements for these claims.

Five putative shareholder derivative actions were filed between October 29, 2007 and November 15, 2007. The first two of these putative shareholder derivative actions, entitled Rosky v. Farha, et al. and Rooney v. Farha, et al., respectively, are supposedly brought on behalf of the Company and were filed in the United States District Court for the Middle District of Florida. Two additional actions, entitled Intermountain Ironworkers Trust Fund v. Farha, et al., and Myra Kahn Trust v. Farha, et al., were filed in Circuit Court for Hillsborough County, Florida. All four of these actions are asserted against all Company directors (and former director Todd Farha) except for D. Robert Graham, Heath Schiesser and Charles G. Berg and also name the Company as a nominal defendant. A fifth action, entitled Irvin v. Behrens, et al., was filed in the United States District Court for the Middle District of Florida and asserts claims against all Company directors (and former director Todd Farha) except Heath Schiesser and Charles G. Berg and against two former Company officers, Paul Behrens and Thaddeus Bereday. All five actions contend, among other things, that the defendants allegedly allowed or caused the Company to misrepresent its reported financial results, in amounts unspecified in the pleadings, and seek damages and equitable relief for, among other things, the defendants supposed breach of fiduciary duty, waste and unjust enrichment. The three actions in federal court have been consolidated. Subsequent to that consolidation, an additional derivative complaint entitled City of Philadelphia Board of Pensions and Retirement Fund v. Farha, et al. was filed in the same federal court, but thereafter was consolidated into the existing consolidated action. A motion to consolidate the two state court actions, to which all parties consented, was granted, and plaintiffs filed a consolidated complaint on April 7, 2008. On October 31, 2008, amended complaints were filed in the federal court and the state court derivative actions. On December 30, 2008, the Company filed substantially similar motions to dismiss both actions, contesting, among other things, the standing of the plaintiffs in each of these derivative actions to prosecute the purported claims in the Company s name. At this time, neither the Company nor any of its subsidiaries can predict the probable outcome of these claims. Accordingly, no amounts have been accrued in the Company s condensed consolidated financial statements for these claims.

Other Lawsuits and Claims

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

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

Forward Looking Statements

Statements contained in this Quarterly Report on Form 10-Q which are not historical fact may be forward-looking statements within the meaning of Section 21E of the Securities Exchange Act of 1934 (the Exchange Act). We intend such statements to be covered by the safe harbor provisions for forward-looking statements contained in Section 21E of the Exchange Act. Such statements, which may address, among other things, market acceptance of our products and services, expansion into new targeted markets, product development, our ability to finance growth opportunities, our ability to respond to changes in government regulations, sales and marketing strategies, projected capital expenditures, liquidity and the availability of additional funding sources may be found in the sections of this report entitled Business, Risk Factors, Management s Discussion and Analysis of Financial Condition and Results of Operations and elsewhere in this report generally. In some cases, you can identify forward-looking statements by terminology such as may, will, should, expects, plans, anticipates, believes, estimates, predicts, potential, continues terms or other comparable terminology. You are cautioned that matters subject to forward-looking statements involve risks and uncertainties, including economic, regulatory, competitive and other factors that may affect our business. These forward-looking statements are inherently susceptible to uncertainty and changes in circumstances, as they are based on management s current expectations and beliefs about future events and circumstances. We undertake no obligation beyond that required by law to update publicly any forward-looking statements for any reason, even if new information becomes available or other events occur in the future.

Our actual results may differ materially from those indicated by forward-looking statements as a result of various important factors including the expiration, cancellation or suspension of our state and federal contracts. In addition, our results of operations and projections of future earnings depend, in large part, on accurately predicting and effectively managing health benefits and other operating expenses. A variety of factors, including competition, changes in health care practices, changes in federal or state laws and regulations or their interpretations, inflation, provider contract changes, changes in or terminations of our contracts with government agencies, new technologies, government-imposed surcharges, taxes or assessments, reduction in provider payments by governmental payors, major epidemics, disasters and numerous other factors affecting the delivery and cost of health care, such as major health care providers inability to maintain their operations, may in the future affect our ability to control our medical costs and other operating expenses. Governmental action or business conditions could result in premium revenues not increasing to offset any increase in medical costs and other operating expenses. Once set, premiums are generally fixed for one-year periods and, accordingly, unanticipated costs during such periods cannot be recovered through higher premiums. Furthermore, if we are unable to accurately estimate incurred but not reported medical costs in the current period, our future profitability may be affected. Due to these factors and risks, we cannot provide any assurance regarding our future premium levels or our ability to control our future medical costs.

From time to time, at the federal and state government levels, legislative and regulatory proposals have been made related to, or potentially affecting, the health care industry, including but not limited to limitations on managed care organizations, including benefit mandates, and reform of the Medicaid and Medicare programs. Any such legislative and regulatory action, including benefit mandates and reform of the Medicaid and Medicare programs, could have the effect of reducing the premiums paid to us by governmental programs, increasing our medical or administrative costs or requiring us to materially alter the manner in which we operate. We are unable to predict the specific content of any future legislation, action or regulation that may be enacted or when any such future legislation or regulation will be adopted. Therefore, we cannot predict accurately the effect or ramifications of such future legislation, action or regulation on our business.

Overview

We provide managed care services exclusively to government-sponsored health care programs, focusing on Medicaid and Medicare, including health plans for families, children and the aged, blind and disabled and prescription drug plans. As of September 30, 2008, we served approximately 2,530,000 members. We believe that this broad range of experience and exclusive government focus allows us to serve efficiently and effectively our members and providers and to manage our operations.

Through our licensed subsidiaries, as of September 30, 2008, we operated our Medicaid health plans in Florida, Georgia, Illinois, Missouri, New York and Ohio. Our Medicare plans include stand-alone PDP and Medicare Advantage plans, which include both MCC plans and PFFS plans. As of September 30, 2008, we offered our MCC plans in Connecticut, Florida, Georgia, Illinois, Indiana, Louisiana, Missouri, New Jersey, New York, Ohio and Texas, and our PDP

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plans in all 50 states and the District of Columbia and our PFFS plans in 43 states and the District of Columbia.

Business Outlook

General Economic, Political and Financial Market Conditions

As a result of economic uncertainty, many of the states in which we operate have experienced significant fiscal challenges, which are likely to result in budget deficits. In light of these budgetary challenges, the Medicaid segment premiums we receive likely will not keep pace with anticipated medical expense increases. While the economic downturn may increase the number of Medicaid recipients under current eligibility criteria, states may revise the eligibility criteria to reduce the number of people who are eligible for our plans. Furthermore, federal budgetary challenges or policy changes could result in rates that do not keep pace with anticipated medical expense increases, which could have a material adverse effect on our performance in the Medicaid or Medicare segments.

In addition, increasing market volatility and the tightening of the credit markets has significantly limited our ability to access external capital, which has, and is likely to continue to have, an adverse effect on our ability to execute our business strategy. However, we continue to pursue financing alternatives to raise additional unregulated cash, including seeking dividends from certain of our regulated subsidiaries and accessing the public and private equity and debt markets.

Government funding continues to be a significant challenge to our business, particularly in light of the current economic conditions. Because the health care services we offer are through government-sponsored programs, our profitability is largely dependent on continued funding for government health care programs at or above current levels. Future Medicaid premium rate levels may be affected by continued government efforts to contain medical costs or state and federal budgetary constraints. Some of the states in which we operate have experienced fiscal challenges leading to significant budget deficits. Health care spending increases appear to be more limited than in the past as states continue to look at Medicaid programs as opportunities for budget savings, and some states may find it difficult to continue paying current rates to Medicaid health plans.

We are experiencing pressure on rates in Florida and Georgia, two states from which we derive a substantial portion of our revenue. In 2008 and 2009, Florida implemented Medicaid rates that were below our expectations and ultimately caused us to withdraw from the Medicaid reform program which will result in a loss of approximately 80,000 members. The withdrawal was originally to be effective May 1, 2009 but was subsequently changed to July 1, 2009. New legislation in Georgia related to payment of claims, eligibility determination and provider contracting, may negatively impact revenues and profits for the plan in 2009 and beyond. Further, continued economic slowdowns in Florida and Georgia, as well as other states, could result in additional state actions that could adversely affect our revenues.

In January 2009, the new presidential administration took office. Although the new administration and recently elected U.S. Congress have expressed some support for measures intended to expand the number of citizens covered by health insurance and other changes within the health care system, the costs of implementing any of these proposals could be financed, in part, by reductions in the payments made to Medicare Advantage and other government programs. For example, CMS recently announced preliminary 2010 Medicare Advantage payment rates that are significantly below our prior expectations. Reduced Medicare rates will not only negatively impact our net income, but could also cause us to reduce the benefits that we offer under our Medicare plans, thereby making them less attractive to potential members. Further, in January 2009, the U.S. Congress approved the children s health bill which, among things, increases federal funding to the State Children s Health Insurance Program (S-CHIP). In addition, in February 2009, President Obama signed the American Recovery and Reinvestment Act that provides funding for, among other things, state Medicaid programs, the modernization of health information technology systems and aid to states to help defray budget cuts. Because of the unsettled nature of these initiatives, the numerous steps required to implement them and the substantial amount of state flexibility for determining how Medicaid and S-CHIP funds will be used, we are currently unable to assess the ultimate impact that they will have on our business.

Medicare Competition and Outlook

In our Medicare segment, we are experiencing increased competition. In August 2008, we were notified by the federal Centers for Medicare & Medicaid Services (CMS) that our bids for the 2009 plan year were below the CMS regional benchmark premium rate in 12 of the 34 CMS regions, which allows us to serve auto-assigned dual-eligible

Medicare beneficiaries. As of January 2009, approximately 252,000 auto-assigned dual-eligible members were assigned away from our plans. In addition, approximately 28,000 low-income subsidized members disenrolled from our plans effective January 2009. In addition, several changes to the Medicare program resulting from Medicare Improvements for Patients and Providers Act (MIPPA) that became effective in 2008 could increase competition for our existing and prospective members, which could adversely affect our revenues.

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In February 2009, we were notified by CMS that, effective March 7, 2009, we were being sanctioned through a suspension of marketing of, and enrollment into, all lines of our Medicare business. This suspension will remain in effect until CMS determines that the suspension should be lifted. Among other areas, CMS s determination was based on findings of deficiencies in our enrollment and disenrollment operations, appeals and grievances, timely and proper responses to beneficiary complaints and requests for assistance and marketing and agent/broker oversight activities. We are working closely with CMS to address their concerns. At this time, we cannot estimate the duration of the suspension or the ultimate impact it will have on our results of operations and our business. Nonetheless, we anticipate that our inability to enroll new Medicare members will have a material negative affect on our results of operations and business in 2009 and potentially beyond. Further, we cannot provide any assurances that we will be able to take appropriate corrective action or that, despite any corrective measures taken on our part, that we will not incur additional penalties, fines or other operating restrictions which could have an additional material adverse effect on our results of operations. Due to uncertainty as to the duration of the suspension, we are in the process of evaluating the effects of this suspension and resulting anticipated revenue loss on the Company s operations. Additionally, we are also assessing the impact of ceasing marketing activities and the resulting loss of membership to determine what effect, if any, this action will have on our staffing needs and other operational capabilities. This assessment may require us to incur additional costs to enhance our operational capabilities or to scale our associate levels to effectively and efficiently meet the needs of the members we serve.

Execution of Business Strategy

To achieve our business strategy, we continue seek economically viable opportunities to expand our business within our existing markets, expand our current service territory and develop new product initiatives. We also are evaluating various strategic alternatives, which may include entering new lines of business or markets, exiting existing lines of business or markets and/or disposing of assets depending on various factors, including changes in our business and regulatory environment, competitive position and financial resources. We continue to rationalize our operations to make sure that our ongoing business is profitable. To the extent that we expand our current service territory or product offerings, we expect to generate additional revenues. On the other hand, if we decide to exit certain markets, as we did during 2008 and early 2009, our revenues could decrease.

We currently do not foresee large, one-time opportunities to expand our business, such as prior efforts like the launch of PDPs in 2006 and the privatization of Georgia Medicaid in 2006. We also intend to divert some resources to strengthening compliance and operating capabilities. These factors, when combined with the rationalization of our operations and the operational challenges we face, could cause us to not sustain the rapid growth we have achieved in the recent past.

Membership and Trends

We provide managed care services targeted exclusively to government-sponsored health care programs, focused on Medicaid and Medicare, including prescription drug plans and health plans for families, children, and the aged, blind and disabled. As of December 31, 2007, we served approximately 2,373,000 members. Most of our revenues are generated by premiums consisting of fixed monthly payments per member.

We currently anticipate that our revenues and medical benefits expenses for fiscal years 2008 and 2009 will be higher than in prior periods due to the changes in the numbers and demographic mix of membership principally occurring in our Medicare Advantage plans and Ohio Medicaid market, and, effective in 2009, in Hawaii. As the composition of our membership base continues to change as the result of programmatic, competitive, regulatory, benefit design, economic or other changes, we expect a corresponding change to our premium revenue, costs and margins which may have a material adverse effect on our cash flow, profitability and results of operations.

Encounter Data

To the extent that our encounter data is inaccurate or incomplete, we may incur additional costs to collect or correct this data and could be exposed to regulatory risk for noncompliance. The accurate and timely reporting of encounter data is crucial to the success of our programs because more states are using encounter data to determine compliance with performance standards which are partly used by such states to set premium rates. As states increase their reliance on encounter data, our inability to obtain complete and accurate encounter data could significantly affect the premium rates we receive and how membership is assigned to us, which could have a material adverse effect on our results of

operations, cash flows and our ability to bid for, and continue to participate in, certain programs.

Financial Impact of Government Investigations and Litigation

We do not know whether, or the extent to which, any pending investigations and related litigation discussed under Part II Item 1 Legal Proceedings will result in our payment of fines, penalties or damages, any of which would require us to incur additional expenses and could have an adverse affect on our results of operations. Furthermore, if as a result of the resolution of these matters we are subject to operating restrictions, revocation of our licenses, termination of one or more of our contracts and/or exclusion from further participation in Medicare or Medicaid programs, our revenues and net income could be adversely affected.

We are engaged in resolution discussions as to matters under review with the U.S. Attorney s Office for the Middle District of Florida (the USAO), the Civil Division of the U.S. Department of Justice (the Civil Division), the Office of Inspector General of the U.S. Department of Health and Human Services (the OIG) and the State of Florida. Based on the current status of matters and all information known to us to date, we have accrued a liability in the amount of $50.0 million in connection with the ultimate resolution of these matters. However, we cannot provide any assurances regarding the likelihood, timing or terms and conditions of any potential negotiated resolution of pending investigations by the USAO, the Civil Division, the OIG or the State of Florida.

The investigations and related matters have caused us to expend significant financial resources. As of December 31, 2008, we had spent a cumulative amount of approximately $124.1 million on administrative expenses associated with, or consequential to, the government and Special Committee investigations, including legal fees, accounting fees, consulting fees, employee recruitment and retention costs and similar expenses. Approximately $21.1 million of these investigation related costs were incurred in 2007 and approximately $103.0 million were incurred in 2008. We expect to continue incurring significant additional costs in 2009 as a result of the federal and state investigations and pending civil actions, including administrative expenses and costs necessary to improve our corporate governance and address other issues that may be identified.

Our Segments

We have two reportable business segments: Medicaid and Medicare.

Medicaid

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

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Medicare

Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons a variety of hospital, medical insurance and prescription drug benefits. Medicare is administered and funded by CMS. Our Medicare segment includes stand-alone PDP and Medicare Advantage plans, which includes CCP, PFFS and PPO plans. Medicare Advantage is Medicare s managed care alternative to original Medicare fee-for-service (Original Medicare), which provides individuals standard Medicare benefits directly through CMS. CCPs are administered through a health maintenance organization and generally require members to seek health care services from a network of health care providers. PFFS plans are offered by insurance companies and are open-access plans that allow members to be seen by any physician or facility that participates in the Original Medicare program and agrees to bill, and otherwise accepts the terms and conditions of, the sponsoring insurance company. PPO plans are also offered by insurance companies and provide both in-network and out-of-network benefits for Medicare beneficiaries.

Membership

The following table summarizes our membership by segment and line of business as of September 30, 2008 and 2007.

	As of September 30,	
	2008	**2007**
Medicaid		
TANF	1,031,000	887,000
S-CHIP	180,000	215,000
SSI	64,000	71,000
FHP	26,000	31,000
	1,301,000	1,204,000
Medicare		
MA	240,000	160,000
PDP	989,000	972,000
	1,229,000	1,132,000
Total	2,530,000	2,336,000

We enter into contracts with government agencies that administer health benefits programs. These contracts generally are subject to renewal every one to four years. We receive premiums from state and federal agencies for the members that are assigned to or have selected us to provide healthcare services under each benefit program. The amount of premiums we receive for each member varies according to demographics, including the government program, and the member s geographic location, age and gender, and the premiums are subject to periodic adjustments.

Medical Benefits Expense

Our largest expense is the cost of medical benefits that we provide, which is based primarily on our arrangements with health care providers and utilization of health care services by our members. Our profitability depends on our ability to predict and effectively manage medical benefits expense relative to the primarily fixed premiums we receive. Our arrangements with providers primarily fall into two broad categories: capitation arrangements, where we pay the capitated providers a fixed fee per member and fee-for-service, as well as risk-sharing arrangements, the provider assumes a portion of the risk of the cost of the health care provided. Other components of medical benefits expense are variable and require estimation and ongoing cost management.

Estimation of medical benefits payable is our most significant critical accounting estimate. See Critical Accounting Policies below.

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

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

Critical Accounting Policies

In the ordinary course of business, we make a number of estimates and assumptions relating to the reporting of our results of operations and financial condition in conformity with accounting principles generally accepted in the United States. We base our estimates on historical experience and on various other assumptions that we believe to be reasonable under the circumstances. Actual results could differ significantly from those estimates under different assumptions and conditions. We believe that the accounting policies discussed below are those that are most important to the portrayal of our financial condition and results and require management s most difficult, subjective and complex judgments, often as a result of the need to make estimates about the effect of matters that are inherently uncertain.

Revenue recognition. Our Medicaid contracts with state governments are generally multi-year contracts subject to annual renewal provisions. Our MA and PDP contracts with CMS generally have terms of one year. We recognize premium revenues in the period in which we are obligated to provide services to our members. We estimate, on an ongoing basis, the amount of member billings that may not be fully collectible or that will be returned based on historical trends, anticipated or actual MBRs, and other factors. An allowance is established for the estimated amount that may not be collectible and a liability for premium expected to be returned. The allowance has not been significant to premium revenue. The payment we receive monthly from CMS for our PDP program generally represents our bid amount for providing prescription drug insurance coverage. We recognize premium revenue for providing this insurance coverage ratably over the term of our annual contract. Premiums collected in advance are deferred and reported as unearned premiums in the accompanying condensed consolidated balance sheets and amounts that have not been received by the end of the period remain on the balance sheet classified as premium receivables.

Premium payments that we receive are based upon eligibility lists produced by our customers. From time to time, the states or CMS may require us to reimburse them for premiums that we received based on an eligibility list that a state or CMS later discovers contains individuals who were not eligible for any government-sponsored program or are eligible for a different premium category, different program, or belong to a different plan other than ours. These adjustments reflect changes in the number of and eligibility status of enrollees subsequent to when revenue was received. We estimate the amount of outstanding retroactivity each period and adjust premium revenue accordingly; if appropriate, the estimates of retroactive adjustments are based on historical trends, premiums billed, the volume of member and contract renewal activity and other information. Our government contracts establish monthly rates per member, but may have additional amounts due to us based on items such as age, working status or medical history. For example, CMS has implemented a risk- adjustment model that apportions premiums paid to all Medicare plans according to the health status of each beneficiary enrolled.

CMS transitioned to the risk adjustment model while the old demographic model was being phased out. The demographic model based the monthly premiums paid to Medicare plans on factors such as age, gender and disability status. The monthly premium amount for each member was separately determined under both the risk adjustment and demographic model, and these separate payment amounts were blended according to a transition schedule. 2007 was the first year in which risk-adjusted payments for health plans were fully phased in. The PDP payment methodology is based 100% on the risk-adjustment model, which began in 2006. Under the risk adjustment model, the settlement payment is based on each member s preceding year medical diagnosis data. The final settlement payment amount under the risk- adjustment model is made in August of the following year, allowing for the majority of medical claim run out. As a result of this process and the phasing in of the risk-adjustment model, our CMS monthly premium

payments per member may change materially, either favorably or unfavorably.

The CMS risk-adjustment model pays more for Medicare members with predictably higher costs. Under this risk-

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adjustment methodology, diagnosis data from inpatient and ambulatory treatment settings are used to calculate the risk-adjusted premium payment to us. We collect claims and encounter data and submit the necessary diagnosis data to CMS within prescribed deadlines. We continually estimate risk-adjusted revenues based upon membership claim activity and the diagnosis data submitted to CMS and, and that which is ultimately accepted by CMS, and record such adjustments in our results of operations. However, due to the variability of the assumptions that we use in our estimates, our actual results may differ from the amounts that we have estimated. If our estimates are materially incorrect, it may have an adverse effect on our results of operations in future periods. Historically, we have not experienced significant differences between the amounts that we have recorded and the revenues that we actually received.

Other amounts included in this balance as a reduction of premium revenue represent the return of premium associated with certain of our Medicaid contracts. These contracts require the Company to expend a minimum percentage of premiums on eligible medical expense, and to the extent that we expend less than the minimum percentage of the premiums on eligible medical expense, we are required to refund all or some portion of the difference between the minimum and our actual allowable medical expense. The Company estimates the amounts due to the state as a return of premium each period based on the terms of the Company s contract with the applicable state agency.

Estimating medical benefits expense and medical benefits payable. The cost of medical benefits is recognized in the period in which services are provided and includes an estimate of the cost of medical benefits that have been incurred but not yet reported. We contract with various health care providers for the provision of certain medical care services to our members and generally compensate those providers on a fee-for-service or capitated basis or pursuant to certain risk-sharing arrangements. Capitation represents fixed payments generally on a per-member-per-month, or PMPM, basis to participating physicians and other medical specialists as compensation for providing comprehensive health care services. Generally, by the terms of most of our capitation agreements, capitation payments we make to capitated providers obviate any further obligation we have to pay the capitated provider for the actual medical expenses of the member.

Medical benefits expense has two main components: direct medical expenses and medically related administrative costs. Direct medical expenses include amounts paid to hospitals, physicians and providers of ancillary services, such as laboratory and pharmacy. Medically related administrative costs include items such as case and disease management, utilization review services, quality assurance and on-call nurses. Medical benefits payable represents amounts for claims fully adjudicated awaiting payment disbursement and estimates for incurred, but not yet reported claims (IBNR).

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

The factors and assumptions described above that are used to develop our estimate of medical benefits expense and medical benefits payable inherently are subject to greater variability when there is more limited experience or information available to us. For example, from 2004 to 2007, we grew at a rapid pace, through the expansion of existing products and introduction of new products, such as Part D and PFFS, and entry into new geographic areas, such as Georgia. The ultimate claims payment amounts, patterns and trends for new products and geographic areas cannot be precisely predicted at their onset, since we, the providers and the members do not have experience in these products or geographic areas. Standard accepted actuarial methodologies require the use of key assumptions consisting of trend and completion factors using an assumption of moderately adverse conditions that would allow for

this inherent variability. This can result in larger differences between the originally estimated medical benefits payable and the actual claims amounts paid. Conversely, during periods where our products and geographies are more stable and mature, we have more reliable claims payment patterns and trend experience. With more reliable data, we should be able to more closely estimate the ultimate claims payment amounts; therefore, we may experience smaller differences between our original estimate of medical benefits payable and the actual claim amounts paid.

Medical cost trends can be volatile and management is required to use considerable judgment in the selection of medical benefits expense trends and other actuarial model inputs. In developing the estimate, we also apply different

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

Many aspects of the managed care business are not predictable. These aspects include the incidences of illness or disease state (such as cardiac heart failure cases, cases of upper respiratory illness, the length and severity of the flu season, diabetes, the number of full-term versus premature births and the number of neonatal intensive care babies). Therefore, we must rely upon historical experience, as continually monitored, to reflect the ever-changing mix, needs and growth of our membership in our trend assumptions. Among the factors considered by management are changes in the level of benefits provided to members, seasonal variations in utilization, identified industry trends and changes in provider reimbursement arrangements, including changes in the percentage of reimbursements made on a capitation as opposed to a fee-for-service basis. These considerations are aggregated in the trend of medical benefits expense. Other external factors such as government-mandated benefits or other regulatory changes, catastrophes and epidemics may affect medical cost trends. Other internal factors such as system conversions and claims processing interruptions may affect our ability to accurately predict historical completion factors or medical cost trends. Medical cost trends potentially are more volatile than other segments of the economy. Management is required to use considerable judgment in the selection of medical benefits expense trends and other actuarial model inputs.

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

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

Goodwill and intangible assets. We obtained Goodwill and intangible assets as a result of the acquisitions of our subsidiaries. Goodwill represents the excess of the cost over the fair market value of net assets acquired. Intangible assets include provider networks, membership contracts, trademarks, non-compete agreements, government contracts, licenses and permits. Our intangible assets are amortized over their estimated useful lives ranging from one to 26 years.

We evaluate 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. We must make assumptions and estimates, such as the discount factor, in determining the estimated fair values. While we believe these assumptions and estimates are appropriate, other assumptions and estimates could be applied and might produce significantly different results.

We review Goodwill and intangible assets for impairment at least annually, or more frequently if events or changes in circumstances occur that may affect the estimated useful life or the recoverability of the remaining balance of goodwill or intangible assets. Events or changes in circumstances would include significant changes in membership,

state funding, medical contracts and provider networks. We have selected the second quarter of each year for our annual impairment test, which generally coincides with the finalization of contract negotiations and our initial budgeting process. We believe Goodwill and intangible assets are not impaired at September 30, 2008. Based on the current general economic conditions and outlook, we are undertaking a review of the underlying valuation of Goodwill and intangibles at December 31, 2008.

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impaired as of September 30, 2008.

Results of Operations

The following table sets forth the condensed consolidated statements of income data, expressed as a percentage of total revenues for each period indicated. The historical results are not necessarily indicative of results to be expected for any future period.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2008	2007	2008	2007
Statement of Operations Data:				
Revenues:				
Premium	99.5%	97.8%	99.3%	98.3%
Investment and other income	0.5%	2.2%	0.7%	1.7%
Total revenues	100.0%	100.0%	100.0%	100.0%
Expenses:				
Medical benefits	88.2%	71.6%	85.7%	78.6%
Selling, general and administrative	14.0%	15.9%	14.0%	13.6%
Depreciation and amortization	0.3%	0.4%	0.3%	0.3%
Interest	0.2%	0.3%	0.2%	0.3%
Total expenses	102.7%	88.2%	100.3%	92.8%
Income before income taxes	(2.7)%	11.8%	(0.3)%	7.2%
Income tax expense	(1.5)%	6.0%	(0.2)%	3.3%
Net Income	(1.2)%	5.8%	(0.1)%	3.9%

One of our primary management tools for measuring profitability is our MBR. Changes in the MBR from period to period result from, among other things, changes in Medicaid and Medicare funding, changes in the mix of Medicaid and Medicare membership, our ability to manage medical costs and changes in accounting estimates related to incurred but not reported claims. We use our MBR both to monitor our management of medical benefits expense and to make various business decisions, including what healthcare plans to offer, what geographic areas to enter or exit and the selection of healthcare providers. Although our MBR plays an important role in our business strategy, we may be willing to enter into provider arrangements that might produce a less favorable MBR if those arrangements, such as capitation or risk-sharing, would likely lower our exposure to variability in medical costs.

Three- and Nine-Month Periods Ended September 30, 2008 Compared to the Three- and Nine-Month Periods Ended September 30, 2007

Premium revenue. Premium revenues for the three months ended September 30, 2008 increased $300.8 million, or 22.6%, to approximately $1.6 billion from approximately $1.3 billion for the same period in the prior year. For the nine months ended September 30, 2008, premium revenues increased approximately $1.0 billion, or 24.5%, to approximately $4.9 billion from approximately $3.9 billion for the same period in the prior year. The increase is primarily attributable to the addition of members from membership growth in both our Medicaid and Medicare segments. Total membership grew by approximately 194,000 members, or 8.3%, from 2,336,000 at September 30, 2007 to 2,530,000 at September 30, 2008.

The Medicaid segment premium revenue for the three months ended September 30, 2008 increased $100.1 million, or 14.9%, to $771.0 million from $671.0 million for the same period in the prior year. For the nine months ended September 30, 2008, Medicaid segment premium revenue increased $298.9 million, or 15.3%, to approximately

$2.3 billion from approximately $2.0 billion for the same period in the prior year. The increase in Medicaid segment revenue is due to year over year growth in membership, which accounted for $79.6 million and $200.0 million in the three- and nine-month periods, respectively. Increased rates accounted for $41.4 million and $153.3 million in the three- and nine-month periods, respectively. These increases were partially offset by our withdrawal from our Connecticut Medicaid market, which accounted for a decrease in premium revenues of approximately $20.9 million and $54.5 million in the three- and nine-month periods, respectively. Aggregate membership in our Medicaid segment grew by 97,000 members, or 8.1%, from 1,204,000 at September 30, 2007 to 1,301,000 at September 30, 2008.

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	Medicaid Revenues and Membership			
	Three Months Ended September 30,		Nine Months Ended September 30,	
	2008	2007	2008	2007
	(Dollars in millions)			
Revenues	$ 771.0	$ 671.0	$ 2,252.7	$ 1,953.8
% of Total Premium Revenues	47.3%	50.5%	46.1%	49.8%
Membership	1,301,000	1,204,000	1,301,000	1,204,000
% of Total Membership	51.4%	51.5%	51.4%	51.5%

The Medicare segment premium revenue for the three months ended September 30, 2008 increased $200.8 million, or 30.5%, to $858.3 million from $657.5 million for the same period in the prior year. For the nine months ended September 30, 2008, Medicare segment premium revenue increased $662.8 million, or 33.6%, to $2.6 billion from $2.0 billion for the same period in the prior year. Growth in premium revenue within the Medicare segment was primarily due to PFFS membership growth, the launch of our Medicare Coordinated Care (MCC) product in Texas and New Jersey, and other MCC membership growth which accounted for $117.1 million, $66.6 million, and $15.2 million of the increase in the three-month period, respectively, and $307.5 million, $85.1 million, and $37.1 million of the increase in the nine-month period, respectively. The remaining increase is associated with increased premium rates in certain Medicare products. Membership within the Medicare segment grew by 97,000 members, or 8.6% from 1,132,000 at September 30, 2007 to 1,229,000 at September 30, 2008, principally due to PDP and the PFFS product.

	Medicare Revenues and Membership			
	Three Months Ended September 30,		Nine Months Ended September 30,	
	2008	2007	2008	2007
	(Dollars in millions)			
Revenues	$ 858.3	$ 657.5	$ 2,634.0	$ 1,971.2
% of Total Premium Revenues	52.7%	49.5%	53.9%	50.2%
Membership	1,229,000	1,132,000	1,229,000	1,132,000
% of Total Membership	48.6%	48.5%	48.6%	48.5%

Investment and other income. Investment and other income for the three months ended September 30, 2008 decreased $21.8 million, or 72.9%, to $8.1 million from $30.0 million for the same period in the prior year. For the nine months ended September 30, 2008, investment income decreased $33.7 million, or 50.5%, to $33.1 million from $66.8 million for the same period in the prior year. The 2007 period included a gain of $8.8 million realized as a result of settlement of an outstanding litigation matter. Excluding this gain, the decrease was primarily due to a lower average invested balances cash balance and reduced market rates.

Medical benefits expense. Medical benefits expense for the three months ended September 30, 2008 increased $470.9 million, or 48.4%, to approximately $1.4 billion from $972.9 million for the same period in the prior year. For the nine months ended September 30, 2008, medical benefits expense increased approximately $1.1 billion, or 34.5%, to approximately $4.2 billion from approximately $3.1 billion for the same period in the prior year. The MBR for the three months ended September 30, 2008 was 88.6% compared to 73.2% for the same period in the prior year. For the nine months ended September 30, 2008, the MBR was 86.3% compared to 79.9% for the same period in the prior year.

Medical Benefits Expense

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2008	2007	2008	2007
	(Dollars in millions)			
Medical Benefits Expense	$ 1,443.7	$ 972.9	$ 4,218.3	$ 3,137.0
IBNR adjustment	(92.8)(1)	101.4(2)	(92.8)(1)	101.4(2)
Medical Benefits Expense as adjusted	$ 1,350.9	$ 1,074.3	$ 4,125.5	$ 3,238.4
MBR as reported	88.6%	73.2%	86.3%	79.9%
MBR as adjusted	82.9%	80.9%	84.4%	82.5%

(1) We believe that Medical Benefits Expense as adjusted for the quarter ended September 30, 2008 is a non-GAAP financial measure because it reflects the favorable development that otherwise would have been recognized in the three- and

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nine-month periods ended September 30, 2008 if the Company had timely filed its 2007 10-K. Due to the delay in filing our 2007 10-K, the Company was able to review substantially complete claims information that had become available due to the substantial lapse in time between December 31, 2007 and the date we filed our 2007 Form 10-K; therefore, the favorable development was reported in 2007 instead of 2008 as it would have normally. The most directly comparable GAAP measure is Medical Benefits Expense, which has been determined based on the actuarially determined methods. Thus, our recorded amounts for Medical Benefits Expense and MBR for the three- and nine-month periods ended September 30, 2008 is approximately $92.8 million higher than it would have otherwise been if we had filed our 2007 10-K on time. Consequently, we believe that Medical Benefits Expense as adjusted for the three- and nine-months ended September 30, 2008 will better facilitate a

year over year comparison of our Medical Benefits Expense.

(2) We believe that Medical Benefits Expense as adjusted for the quarter ended September 30, 2007 is a non-GAAP financial measure because it does not take into account the claims information that has become available as of the date of filing of this Quarterly Report on Form 10-Q. The most directly comparable GAAP measure is Medical Benefits Expense, which has been determined based on the substantially complete claims information that has subsequently become available as of the date of filing this Quarterly Report on Form 10-Q. Consequently, the amounts we recorded in accordance with GAAP for medical benefits expense for the nine months ended September 30, 2007 are based on actual claims paid. The difference between Medical Benefits Expense and Medical Benefits Expense as adjusted is approximately $101.4 million. Thus, our recorded amounts for Medical Benefits Expense and MBR for

the three- and nine-month periods ended September 30, 2007 both include the effect of using actual claims paid. Consequently, we believe that Medical Benefits Expense as adjusted for the three- and nine-month periods ended September 30, 2007, which is based on our actuarially-determined estimate, will better facilitate a year over year comparison of our Medical Benefits Expense.

The Medicaid segment medical benefits expense for the three months ended September 30, 2008 increased $194.8 million, or 39.6%, to $686.9 million from $492.1 million for the same period in the prior year. For the nine months ended September 30, 2008, Medicaid medical benefits expense increased $351.8 million, or 22.4%, to approximately $1.9 billion from approximately $1.6 billion for the same period in the prior year.

	Medicaid Medical Benefits Expense			
	Three Months Ended September 30,		Nine Months Ended September 30,	
	2008	2007	2008	2007
	(Dollars in millions)			
Medicaid Medical Benefits Expense	$ 686.9	$ 492.1	$ 1,919.5	$ 1,567.7
IBNR adjustment	(39.5)(1)	44.8(2)	(39.5)(1)	44.8(2)
Medicaid Medical Benefits Expense as adjusted	$ 647.4	$ 536.9	$ 1,880.0	$ 1,612.5
MBR as reported	89.1%	73.3%	86.3%	80.2%
MBR as adjusted	84.0%	80.0%	83.5%	82.5%

(1) We believe that Medicaid Medical Benefits Expense as adjusted for the quarter ended September 30, 2008 is a non-GAAP financial measure because it reflects the favorable development that otherwise would have been recognized in the three- and

nine-month periods ended September 30, 2008 if the Company had timely filed its 2007 10-K. Due to the delay in filing our 2007 10-K, the Company was able to review substantially complete claims information that had become available due to the substantial lapse in time between December 31, 2007 and the date we filed our 2007 Form 10-K; therefore, the favorable development was reported in 2007 instead of 2008 as it would have normally. The most directly comparable GAAP measure is Medicaid Medical Benefits Expense, which has been determined based on the actuarially determined methods. Thus, our recorded amounts for Medicaid Medical Benefits Expense and MBR for the three- and nine-month periods ended September 30, 2008 is approximately $39.5 million higher than it would have otherwise been if we had filed our 2007 10-K on time, and utilized our actuarially determined estimates versus actual claims paid that subsequently became available. Consequently, we believe that Medicaid Medical Benefits

Expense as adjusted for the three- and nine-months ended September 30, 2008, which is based on our actuarially-determined estimate, will better facilitate a year over year comparison of our Medicaid Medical Benefits Expense.

(2) We believe that Medicaid Medical Benefits Expense as adjusted for the quarter ended September 30, 2007 is a non-GAAP financial measure because it does not take into account the claims information that has become available as of the date of filing of this Quarterly Report on Form 10-Q. The most directly comparable GAAP measure is Medical Benefits Expense, which has been determined based on the substantially complete claims information that has subsequently become

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available as of the date of filing this Quarterly Report on Form 10-Q. Consequently, the amounts we recorded in accordance with GAAP for medical benefits expense for the nine months ended September 30, 2007 are based on actual claims paid. The difference between Medicaid Medical Benefits Expense and Medicaid Medical Benefits Expense as adjusted is $44.8 million. Thus, our recorded amounts for Medicaid Medical Benefits Expense and MBR for the three- and nine-month periods ended September 30, 2007 both include the effect of using actual claims paid. Consequently, we believe that Medicaid Medical Benefits Expense as adjusted for the three- and nine-month periods ended September 30, 2007, which is based on our actuarially-determined estimate, will better facilitate a year over year comparison of our Medical Benefits Expense.

The Medicaid segment medical benefits expense as adjusted for the three months ended September 30, 2008 increased $110.5 million, or 20.6%, to $647.4 million from $536.9 million for the same period in the prior year. For the nine months ended September 30, 2008, Medicaid medical benefits as adjusted expense increased $267.5 million, or 16.6%, to approximately $1.9 billion from approximately $1.6 billion for the same period in the prior year.

The increase in Medicaid medical benefits expense for the three-month period ended September 30, 2008 was primarily due to growth in membership. Membership growth accounted for $53.7 million and $155.9 million of the

increase in the three- and nine-month periods, respectively. This increase was partially offset by our withdrawal from the Connecticut Medicaid market, which decreased our medical expenses by $13.4 million and $46.8 million, in the three- and nine-month periods, respectively. The remaining $70.2 million and $158.4 million of the increase in the three- and nine-month periods are attributed to overall increased utilization patterns and costs. The Medicaid MBR for the three-months period ended September 30, 2008 was 84.0% compared to the 80.0% Medicaid MBR as adjusted same period in the prior year. The Medicaid MBR for the nine-month period ended September 30, 2008 was 83.5% compared to the 82.5% Medicaid MBR as adjusted same period in the prior year.

Medicare segment medical benefits expense for the three months ended September 30, 2008 increased $276.1 million, or 57.4%, to $756.9 million from $480.7 million for the same period in the prior year. Medicare segment medical benefits expense for the nine months ended September 30, 2008 increased $729.4 million, or 46.5%, to approximately $2.3 billion from approximately $1.6 billion for the same period in the prior year.

	Medicare Medical Benefits Expense			
	Three Months Ended September 30,		Nine Months Ended September 30,	
	2008	2007	2008	2007
	(Dollars in millions)			
Medicare Medical Benefits Expense	$ 756.9	$ 480.7	$ 2,298.7	$ 1,569.3
IBNR adjustment	(53.4)(1)	56.6(2)	(53.4)(1)	56.6(2)
Medicare Medical Benefits Expense as adjusted	$ 703.5	$ 537.3	$ 2,245.3	$ 1,625.9
MBR as reported	88.2%	73.1%	87.3%	79.6%
MBR as adjusted	82.0%	81.7%	85.2%	82.5%

(1) We believe that Medicare Medical Benefits Expense as adjusted for the quarter ended September 30, 2008 is a non-GAAP financial measure because it reflects the favorable development that otherwise would have been recognized in the three- and nine-month periods ended September 30, 2008 if the Company had timely filed its 2007 10-K. Due to the delay in filing our 2007 10-K, the Company was able to review substantially complete claims information that had become available due to the substantial lapse

in time between December 31, 2007 and the date we filed our 2007 10-K; therefore, the favorable development was reported in 2007 instead of 2008 as it would have normally. The most directly comparable GAAP measure is Medicare Medical Benefits Expense, which has been determined based on the actuarially determined methods. Thus, our recorded amounts for Medicare Medical Benefits Expense and MBR for the three- and nine-month periods ended September 30, 2008 is approximately $53.4 million higher than it would have otherwise been if we had filed our 2007 Form 10-K on time, and utilized our actuarially determined estimates versus actual claims paid that subsequently became available. Consequently, we believe that Medicare Medical Benefits Expense as adjusted for the three- and nine-months ended September 30, 2008, which is based on our actuarially-determined estimate, will better facilitate a year over year comparison of our Medicare Medical Benefits Expense.

(2) We believe that Medicare Medical Benefits Expense as adjusted for the quarter ended September 30, 2007 is a non-

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GAAP financial measure because it does not take into account the claims information that has become available as of the date of filing of this Quarterly Report on Form 10-Q. The most directly comparable GAAP measure is Medicare Medical Benefits Expense, which has been determined based on the substantially complete claims information that has subsequently become available as of the date of filing this Quarterly Report on Form 10-Q. Consequently, the amounts we recorded in accordance with GAAP for medical benefits expense for the nine months ended September 30, 2007 are based on actual claims paid. The difference between Medicare Medical Benefits Expense and Medicare Medical Benefits Expense as adjusted is $56.6 million. Thus, our recorded amounts for Medicare Medical Benefits Expense and MBR for the three- and nine-month periods ended September 30, 2007 both include the effect of using actual claims paid. Consequently, we believe that Medicaid

Medical Benefits Expense as adjusted for the three- and nine-month periods ended September 30, 2007, which is based on our actuarially-determined estimate, will better facilitate a year over year comparison of our Medicare Medical Benefits Expense.

Medicare segment medical benefits expense as adjusted for the three months ended September 30, 2008 increased $166.2 million, or 30.9%, to $703.5 million from $537.3 million for the same period in the prior year. Medicare segment medical benefits expense as adjusted for the nine months ended September 30, 2008 increased $619.4 million, or 38.1%, to approximately $2.3 billion from approximately $1.6 billion for the same period in the prior year.

The increase in medical benefits expense as adjusted was primarily due to membership growth, principally in our PFFS product and our MCC product, including the launch of our MCC product in Texas and New Jersey, which accounted for approximately $83.7 million, $51.5 million, and $152 million in the three-month period, respectively, and approximately $242.0 million, $65.7 million, and $29.9 million in the nine-month period, respectively. Higher utilization costs in our PDP product contributed an additional $25.4 million and $76.3 million in the three- and nine-month periods, respectively. The Medicare MBR as adjusted for the three-month period ended September 30, 2008 was 82.0% compared to the 81.7% Medicare MBR as adjusted for the same period in the prior year. The Medicaid MBR for the nine months ended September 30, 2008 was 85.2% compared to the 82.5% Medicare MBR as adjusted for the same period in the prior year.

Selling, general and administrative expense. Selling, general and administrative (SG&A) expense for the three months ended September 30, 2008 increased $12.7 million, or 5.9%, to $228.8 million from $216.1 million for the same period in the prior year. For the nine months ended September 30, 2008, SG&A expense increased $146.9 million, or 27.0%, to $690.3 million from $543.5 million for the same period in the prior year. Our SG&A expense to total revenue ratio (SG&A ratio) was 14.0% for the three months ended September 30, 2008 compared to 15.9% for the same period in the prior year. For the nine-month period ended September 30, 2008, our SG&A ratio was 14.0% compared to 13.6% for the same period in the prior year. The increase in SG&A expense was primarily due to the administrative expenses associated with, or consequential to, the government and Special Committee investigations, including legal fees, accounting fees, consulting fees, employee recruitment and retention costs and similar expenses in the amount of $23.0 million during the three-month period and $87.0 million during the nine-month period. These expenses contributed to the increase in our SG&A ratio by approximately 1.4% and 1.7% in the three- and nine-month periods ended September 30, 2008, respectively. The increase resulting from the Special Committee costs were partially offset by the $50.0 million accrual that was recorded in our financial statements in connection with the resolution of the investigation related matters discussed in Note 7 to the Condensed Consolidated Financial Statements for the period ended September 30, 2007. This expense contributed to the increase in our SG&A ratio by approximately 3.1% and 1.3% in the three- and nine-month periods ended September 30, 2007, respectively.

	Selling, General and Administrative Expense			
	Three Months Ended September 30,		**Nine Months Ended September 30,**	
	2008	**2007**	**2008**	**2007**
	(Dollars in millions)			
SG&A	$228.8	$216.1	$690.3	$543.5

SG&A expense to total revenue ratio	14.0%	15.9%	14.0%	13.6%

Depreciation and amortization expense. Depreciation and amortization expense for the three months ended September 30, 2008 increased $0.5 million, or 9.4%, to $5.4 million from $4.9 million for the same period in the prior year. For the nine months ended September 30, 2008, depreciation and amortization expense increased $2.0 million, or 14.7%, to $15.8 million from $13.7 million for the same period in the prior year.

Interest expense. Interest expense was $3.0 million and $3.4 million for the three months ended September 30, 2008

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and 2007, respectively, and $9.2 million and $10.3 million for the nine months ended September 30, 2008 and 2007, respectively.

Income tax expense. Income tax expense for the three months ended September 30, 2008 was $(25.3) million with an effective tax rate of 58.2% as compared to $81.7 million for the same period in the prior year with an effective tax rate of 50.7%. Income tax expense for the nine months ended September 30, 2008 was $(8.0) million with an effective tax rate of 58.2% as compared to $130.3 million for the same nine-month period in the prior year with an effective tax rate of 45.4%. The increases in the effective tax rate for the three- and nine-month periods are attributed to the non-deductibility of certain compensation costs and state taxes, partially off-set by the benefit of tax exempt income.

	Income Tax Expense			
	Three Months Ended September 30,		Nine Months Ended September 30,	
	2008	2007	2008	2007
	(Dollars in millions)			
Income tax expense	$(25.3)	$81.7	(8.0)	$130.3
Effective tax rate	58.2%	50.7%	58.2%	45.4%

Net income. Net income for the three months ended September 30, 2008 was $(18.2) million compared to $79.3 million for the same period in the prior year, representing a decrease of 122.9%. For the nine months ended September 30, 2008, net income was $(5.7) million compared to $157.0 million for the same period in the prior year, representing a decrease of 103.6%. The decrease in net income when comparing the three- and nine-month periods ended September 30, 2008 and 2007 is primarily due to the increase in SG&A expenses associated with, or consequential to, the government and Special Committee investigations in the amount of $14.9 million after taxes during the three-month period and $56.6 million during the nine-month period and the period-over-period increase in MBR, as medical benefits expense grew at a faster pace that premium revenues during the three- and nine-month periods ended September 30, 2008.

	Net Income			
	Three Months Ended September 30,		Nine Months Ended September 30,	
	2008	2007	2008	2007
	(Dollars in millions, except per share data)			
Net income	$(18.2)	$79.3	$ (5.7)	$157.0
Net income per diluted share	$(0.44)	$1.88	$(0.14)	$ 3.74

Liquidity and Capital Resources

Cash Generating Activities

Our business consists of operations conducted by our regulated subsidiaries, including HMOs and insurance subsidiaries, and our non-regulated subsidiaries. The primary sources of cash for our regulated subsidiaries include premium revenue, investment income and capital contributions made by us to our regulated subsidiaries. Our regulated subsidiaries are each subject to applicable state regulations that, among other things, require the maintenance of minimum levels of capital and surplus.

Our regulated subsidiaries primary uses of cash include payment of medical expenses, management fees to our non-regulated third-party administrator subsidiary (the TPA) and direct administrative costs, which are not covered by the agreement with the TPA, such as selling expenses and legal costs. We refer collectively to the cash and investment balances maintained by our regulated subsidiaries as regulated cash and regulated investments, respectively.

The primary sources of cash for our non-regulated subsidiaries are management fees received from our regulated subsidiaries, investment income and cash received from debt or equity offerings. Our non-regulated subsidiaries primary uses of cash include payment of administrative costs not charged to our regulated subsidiaries for corporate

functions, including administrative services related to claims payment, member and provider services and information technology. Other primary uses include capital contributions made by our non-regulated subsidiaries to our regulated subsidiaries and repayment of debt. We refer collectively to the cash and investment balances available in our non-regulated subsidiaries as unregulated cash and unregulated investments, respectively. Cash and cash equivalents, which appears as a line item in our Consolidated Balance Sheet, is the sum of regulated cash and unregulated cash, and Investments, which also appears as a line item in our Consolidated Balance Sheet, is the sum of regulated investments and unregulated investments.

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Cash Positions and Credit Facility

At September 30, 2008 and 2007, cash and cash equivalents were $1,176.3 million and $1,203.4 million, respectively. We also had short-term investments of $77.3 million and $286.3 million at September 30, 2008 and 2007, respectively.

As of September 30, 2008, our consolidated cash and cash equivalents were approximately $1,176.3 million. As of September 30, 2008, our consolidated investments were approximately $133.3 million. As of September 30, 2008, we had unregulated cash of approximately $88.3 million and unregulated investments of approximately $5.2 million. In addition, as of September 30, 2008, we had approximately $997.4 million in regulated cash and $128.1 million in regulated investments.

On December 31, 2008, three of our Florida regulated subsidiaries declared dividends to one of our non-regulated subsidiaries in the aggregate amount of $105.1 million, two of which were paid on December 31, 2008 and one of which was paid on January 2, 2009. On December 31, 2008, three of our Florida regulated subsidiaries declared dividends to one of our non-regulated subsidiaries in the aggregate amount of $105.1 million, two of which were paid on December 31, 2008 and one of which was paid on January 2, 2009. As of December 31, 2008, our consolidated cash and cash equivalents were approximately $1,181.9 million. As of December 31, 2008, our consolidated short-term investments were approximately $70.1 million. As of December 31, 2008, we had unregulated cash of approximately $147.7 million and unregulated investments of approximately $4.9 million. In addition, as of December 31, 2008, we had approximately $958.3 million in regulated cash and $120.3 million in regulated investments. The proceeds from the intercompany dividends discussed above are not reflected in our unregulated cash balances as of September 30, 2008, but are, with the exception of dividends received on January 2, 2009, reflected in our unregulated cash balances as of December 31, 2008.

Our senior secured credit facility with Wachovia Bank, as Administrative Agent, and a syndicate of lenders, which has a term loan facility with an outstanding balance of approximately $152.8 million as of December 31, 2008, is currently in default and subject to acceleration by the lenders and, absent acceleration by the lenders, will become due and payable on May 13, 2009. Taking into account, among other things, the increase in our unregulated cash balances as a result of our receipt of the $105.1 million in dividends described above, we currently expect that we will be able to repay in full the outstanding balance under the credit facility when it becomes due. However, we cannot provide any assurances that adverse developments will not arise that impede our ability to repay in full the outstanding balance under the credit facility when it becomes due. In particular, the timing and amount of any potential resolution with the USAO, the Civil Division, the OIG and the State of Florida is uncertain and could materially and adversely affect our ability to meet our near-term obligations, including repayment of the outstanding balance under the credit facility. Also, our ability to repay in full the outstanding balance under the credit facility could be materially and adversely affected if, among other things, Florida regulators were to require certain of our intercompany loan arrangements which total approximately $50 million, to be terminated. Additionally, one or more of our regulators could require one or more of our subsidiaries to maintain minimum levels of statutory net worth in excess of the amount required under the applicable state laws if the regulators were to determine that such a requirement were in the interest of our members. For example, a state regulator recently notified us that in its view, notwithstanding a parental guarantee that has been in place since 2006, two of our HMOs should contribute a total of approximately $30.0 million in additional statutory capital. We are currently in discussions with the regulator to determine the necessity of a capital contribution, if any, into these regulated entities. In addition, there may be other potential adverse developments that could impede our ability to repay in full the outstanding balance under the credit facility.

We are pursuing financing alternatives to raise additional unregulated cash. Some of these initiatives include, but are not limited to, considering additional dividends from certain of our regulated subsidiaries to the extent that we are able to access available excess capital. Refer to our 2007 10-K for further discussion on, among other things, our Regulatory Capital and Restrictions on our Dividends and Management Fees. In addition to seeking dividends from certain of our regulated subsidiaries, our strategies include accessing the public and private debt and equity markets and potentially selling assets.

Our ability to obtain financing has been and continues to be materially and negatively affected by a number of factors. The recent turmoil in the credit markets, market volatility, the deterioration in the soundness of certain

financial institutions and general adverse economic conditions have caused the cost of prospective debt financings to increase considerably. These circumstances have materially adversely affected liquidity in the financial markets, making terms for certain financings unattractive, and in some cases have resulted in the unavailability of financing. We also believe the uncertainty created by the ongoing state and federal investigations is affecting our ability to obtain financing. In light of the current and evolving credit market crisis and the uncertainty created by the ongoing investigations, we may not be able to obtain financing. Even if we are able to obtain financing under these circumstances, the cost to us likely will be high and the terms and conditions likely will be onerous.

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Our current liquidity position is discussed in detail in our 2007 10-K under Part II Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations Liquidity and Capital Resources. In that section, we provide information related to, among other things, our Regulatory Capital and Restrictions on our Dividends and Management Fees.

Auction Rate Securities

As of September 30, 2008, $56.0 million of our $133.3 million in short- and long-term investments were comprised of municipal notes investments with an auction reset feature (auction rate securities). These notes, which carry investment grade credit ratings, are issued by various state and local municipal entities for the purpose of financing student loans, public projects and other activities. Subsequent to September 30, 2008, $4.4 million of auction rate securities that we held at the balance sheet date either were sold at par or had their interest rate reset through a successful auction.

Each of our existing and anticipated sources of cash is impacted by operational and financial risks that influence the overall amount of cash generated and the capital available to us. For a further discussion of risks that can affect our liquidity, see the risk factor discussion included in our 2007 10-K and this Quarterly Report on Form 10-Q.

Overview of Cash Flow Activities

For the nine-month periods ended September 30, 2008 and 2007 our cash flows are summarized as follows:

	Nine Months Ended September 30,	
	2008	**2007**
	(In millions)	
Net cash provided by operations	$ 170.0	$ 367.5
Net cash used in investing activities	(8.8)	(206.8)
Net cash provided by financing activities	6.7	78.1

Cash from Operations: As we generally receive premiums in advance of payments of claims for healthcare services, we maintain balances of cash and cash equivalents pending payment of claims. During the nine-month period ended September 30, 2008, cash provided by operations consisted primarily of an increase in Medical benefits payable of $231.4 million, $73.1 million from the decrease in Premiums and other receivables, net, partially off-set by a cash out-flow of $101.0 million due to the decrease in Other payables to government partners.

Cash used in Investing Activities: During the nine-month period ended September 30, 2008, investing activities primarily consisted of cash generated by the sale of various short-term investment instruments in the amount of approximately $115.2 million, net of purchases, as well as cash used in investing activities of approximately $110.6, net of proceeds received on sales of restricted investments.

Cash from Financing Activities: Included in financing activities are funds held for the benefit of others, which increased approximately $7.1 million as of September 30, 2008. These PDP member subsidies represent pass-through payments from government partners and are not accounted for in our results of operations since they represent pass-through payments from our government partners to fund deductibles, co-payments and other member benefits for certain of our members.

As discussed above, our senior secured credit facility is currently in default and subject to acceleration by the lenders and will become due and payable on May 13, 2009. The term loan and revolving credit facilities were secured by a pledge of substantially all of the assets or our non-regulated entities, which includes the stock of our operating subsidiaries directly held by our non-regulated entities. Interest is payable quarterly, currently at a rate equal to the sum of a rate based upon Prime rate plus a rate equal to 1.50%. If we fail to pay any of our indebtedness when due, or if we breach any of the other covenants in the instruments governing our indebtedness, it may result in one or more events of default.

As of September 30, 2008, our senior debt was rated B by Standard & Poor s and Ba2 by Moody s. Subsequent to the balance sheet date presented, but prior to the filing of this Quarterly Report on Form 10-Q, our senior debt was downgraded to B- by Standard & Poor s.

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Item 3. Quantitative and Qualitative Disclosures about Market Risk.

As of September 30, 2008, we had cash and cash equivalents of $1,176.3 million, investments classified as current assets of $77.3 million, and restricted investments on deposit for licensure of $199.9 million. The short-term investments classified as current assets consist of highly liquid securities with maturities between three and twelve months and longer term bonds with floating interest rates that are considered available for sale. Long-term restricted assets consist of cash and cash equivalents deposited or pledged to state agencies in accordance with state rules and regulations. These restricted assets are classified as long term regardless of the contractual maturity date due to the long-term nature of the states requirements. The investments classified as long-term are subject to interest rate risk and will decrease in value if market rates increase. Because of their short-term pricing nature, however, we would not expect the value of these investments to decline significantly as a result of a sudden change in market interest rates. Assuming a hypothetical and immediate 1.0% increase in market interest rates at September 30, 2008, the fair value of our fixed income investments would decrease by less than $0.1 million. Similarly, a 1.0% decrease in market interest rates at September 30, 2008 would result in an increase of the fair value of our short-term investments of less than $0.8 million.

Item 4. Controls and Procedures.

Evaluation of Disclosure Controls and Procedures

Our management carried out an evaluation required by Rule 13a-15 under the Exchange Act, under the leadership and with the participation of our President and Chief Executive Officer (CEO) and Chief Financial Officer (CFO), of the effectiveness of our disclosure controls and procedures as defined in Rule 13a-15 under the Exchange Act (Disclosure Controls). Based on the evaluation, our CEO and CFO concluded that, as of September 30, 2008, our Disclosure Controls were effective in timely alerting them to material information required to be included in our reports filed with the SEC.

Changes in Internal Control

There has not been any change in our internal control over financial reporting (as defined in Rule 13a-15(f) of the Exchange Act) identified in connection with the evaluation required by Rule 13a-15(d) under the Exchange Act during the quarter ended September 30, 2008 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

For further discussion of enhancements to our internal controls and remedial measures taken, refer to Part II Item 9A Controls and Procedures in our 2007 10-K.

Limitations on the Effectiveness of Controls

Our management, including our CEO and CFO, does not expect that our Disclosure Controls and internal controls will prevent all errors and fraud. A control system, no matter how well conceived and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues and instances of fraud, if any, within the Company have been detected. These inherent limitations include the realities that judgments in decision-making can be faulty and that breakdowns can occur because of simple error or mistake. Additionally, controls can be circumvented by the individual acts of some persons, by collusion of two or more people or by management override of the controls.

The design of any system of control also is based in part upon certain assumptions about the likelihood of future events, and there can be no assurance that any design will succeed in achieving its stated goals under all potential future conditions; over time, a control may become inadequate because of changes in conditions or the degree of compliance with the policies or procedures may deteriorate. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and may not be detected.

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Part II OTHER INFORMATION

Item 1. Legal Proceedings.

Set forth below is information relating to pending legal proceedings, including a description of the current status of the ongoing investigations, actions and lawsuits arising from or consequential to these investigation:

Government Investigations

We are currently under investigation by several federal and state authorities, including AHCA, the USAO, the Civil Division, the OIG and the and the Florida Attorney General s Medicaid Fraud Control Unit. We are engaged in resolution discussions as to matters under review with the USAO, the Civil Division, the OIG and the State of Florida. Based on the current status of matters and all information known to us to date, we have accrued a liability in the amount of $50.0 million in our financial statements in connection with the ultimate resolution of these matters. However, we cannot provide any assurances regarding the likelihood, timing or terms and conditions of any potential negotiated resolution of pending investigations by the USAO, the Civil Division, the OIG or the State of Florida. However, the timing and amount of any potential resolution are uncertain.

In addition to the federal and state governmental investigations referenced above, as previously disclosed, the SEC is conducting an informal investigation. We also are responding to subpoenas issued by the State of Connecticut Attorney General s Office involving transactions between the Company and its affiliates and their potential impact on the costs of Connecticut s Medicaid program. We have communicated with regulators in states in which our HMO and insurance operating subsidiaries are domiciled regarding the investigations. We are cooperating with federal and state regulators and enforcement officials in these matters. We do not know whether, or the extent to which, any pending investigations might lead to the payment of fines, penalties or operating restrictions.

In addition, in a letter dated October 15, 2008, the Civil Division informed counsel to the Special Committee that as part of the pending civil inquiry, the Civil Division is investigating a number of *qui tam* complaints filed by relators against us under the whistleblower provisions of the False Claims Act, 31 U.S.C. sections 3729-3733. The seal in those cases has been partially lifted for the purpose of authorizing the Civil Division to disclose to us the existence of the *qui tam* complaints. The complaints otherwise remain under seal as required by 31 U.S.C. section 3730(b)(3). We and the Special Committee are undertaking to discuss with the Civil Division, and address, allegations by the *qui tam* relators.

We also learned from a docket search that a former employee filed a *qui tam* action on October 25, 2007 in state court for Leon County, Florida against several defendants, including us and one of our subsidiaries. Because *qui tam* actions brought under federal and state false claims acts are sealed by the court at the time of filing, we are unable to determine the nature of the allegations and, therefore, we do not know at this time whether this action relates to the subject matter of the federal investigations. It is possible that additional *qui tam* actions have been filed against us and are under seal. Thus, it is possible that we are subject to liability exposure under the False Claims Act, or similar state statutes, based on *qui tam* actions other than those discussed in this Quarterly Report on Form 10-Q.

Class Action and Derivative Lawsuits

Putative class action complaints were filed on October 26, 2007 and November 2, 2007. These putative class actions, entitled Eastwood Enterprises, L.L.C. v. Farha, et al. and Hutton v. WellCare Health Plans, Inc. et al., respectively, were filed in the United States District Court for the Middle District of Florida against the Company; Todd Farha, the Company s former chairman and chief executive officer; and Paul Behrens, the Company s former senior vice president and chief financial officer. Messrs. Farha and Behrens were also officers of various subsidiaries of the Company. The Eastwood Enterprises complaint alleges that the defendants materially misstated the Company s reported financial condition by, among other things, purportedly overstating revenue and understating expenses in amounts unspecified in the pleading in violation of the Securities Exchange Act of 1934, as amended. The Hutton complaint alleges that various public statements supposedly issued by defendants were materially misleading because they failed to disclose that the Company was purportedly operating its business in a potentially illegal and improper manner in violation of applicable federal guidelines and regulations. The complaint asserts claims under the Securities Exchange Act of 1934, as amended. Both complaints seek, among other things, certification as a class action and damages. The two actions have been consolidated, and various parties and law firms filed motions seeking to be designated as Lead Plaintiff and Lead Counsel. In an Order issued on

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March 11, 2008, the Court appointed a group of five public pension funds from New Mexico, Louisiana and Chicago as Lead Plaintiffs. On October 31, 2008, an amended consolidated complaint was filed in this class action against the Company, Messrs. Farha and Behrens, and adding Thaddeus Bereday, the Company s former senior vice president and general counsel, as a defendant. On January 23, 2009, the Company and certain other defendants filed a joint motion to dismiss the amended consolidated complaint, arguing, among other things, that the complaint failed to allege a material misstatement by defendants with respect to the Company s compliance with marketing and other health care regulations and failed to plead facts raising a strong inference of scienter with respect to all aspects of the purported fraud claim. The Company intends to defend itself vigorously against these claims. At this time, neither the Company nor any of its subsidiaries can predict the probable outcome of these claims. Accordingly, no amounts have been accrued in the Company s consolidated financial statements for these claims.

Five putative shareholder derivative actions were filed between October 29, 2007 and November 15, 2007. The first two actions, entitled Rosky v. Farha, et al. and Rooney v. Farha, et al., respectively, are purportedly brought on behalf of the Company and were filed in the United States District Court for the Middle District of Florida. Two additional actions, entitled Intermountain Ironworkers Trust Fund v. Farha, et al., and Myra Kahn Trust v. Farha, et al., were filed in Circuit Court for Hillsborough County, Florida. All four of these actions are asserted against all Company directors (and former director Todd Farha) except for D. Robert Graham, Heath Schiesser and Charles G. Berg and also name the Company as a nominal defendant. A fifth action, entitled Irvin v. Behrens, et al., was filed in the United States District Court for the Middle District of Florida and asserts claims against all Company directors (and former director Todd Farha) except Heath Schiesser and Charles G. Berg and against two former Company officers, Paul Behrens and Thaddeus Bereday. All five actions contend, among other things, that the defendants allegedly allowed or caused the Company to misrepresent its reported financial results, in amounts unspecified in the pleadings, and seek damages and equitable relief for, among other things, the defendants supposed breach of fiduciary duty, waste and unjust enrichment. The three actions in federal court have been consolidated. Subsequent to that consolidation, an additional derivative complaint entitled City of Philadelphia Board of Pensions and Retirement Fund v. Farha, et al. was filed in the same federal court, but thereafter was consolidated into the existing consolidated action. A motion to consolidate the two state court actions, to which all parties consented, was granted, and plaintiffs filed a consolidated complaint on April 7, 2008. On October 31, 2008, amended complaints were filed in the federal court and the state court derivative actions. On December 30, 2008, the Company filed substantially similar motions to dismiss both actions, contesting, among other things, the standing of the plaintiffs in each of these derivative actions to prosecute the purported claims in the Company s name. At this time, neither the Company nor any of its subsidiaries can predict the probable outcome of these claims. Accordingly, no amounts have been accrued in the Company s consolidated financial statements for these claims.

Other Lawsuits and Claims

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

Item 1A. Risk Factors.

Under Part I Item 1A Risk Factors of our 2007 10-K, we set forth risk factors related to (i) our failure to file timely periodic reports with the SEC and certain regulatory filings with state agencies; (ii) our internal control over financial reporting; (iii) the pending government investigations and litigation; (iv) our business; (v) our financial condition; (vi) being a regulated entity, and (vii) our common stock. You should carefully consider the risk factors set forth in our 2007 10-K. As of the date hereof, there have been no material changes to the risk factors set forth in our 2007 10-K other than as discussed below.

Risks Related to Our Business

If our government contracts are not renewed or are renewed on substantially different terms, are terminated or become subject to an enrollment freeze, our business, financial condition, results of operations and cash flows could be materially adversely affected.

We provide our Medicaid, Medicare, S-CHIP and other services through a limited number of contracts with state, federal or local government agencies. These contracts generally have terms of one to four years and are subject to non-

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renewal by the applicable government agency. All of our government contracts are terminable for cause if we breach a material provision of the contract or violate relevant laws or regulations.

Our federal and state government contracts are generally subject to cancellation, non-renewal or a potential freeze on enrollment in the event of the unavailability of adequate program funding, compliance violations or for other reasons. In some jurisdictions, a cancellation or enrollment freeze may be immediate, while in other jurisdictions a notice period is required. For example, during 2008, we were subject to a 60-day Medicaid marketing freeze in three counties in Florida resulting from the state s allegation of wrongful marketing practices. Further in February 2009, we were notified by CMS that, effective March 7, 2009, we were being sanctioned through a suspension of marketing of, and enrollments into, all lines of our Medicare business, 2009. This suspension will remain in effect until CMS determines that the suspension should be lifted. At this time, we cannot estimate the duration of the suspension and are evaluating the impact that it could have on our results of operations and business. Nonetheless, we anticipate that our inability to perform marketing activities to, or enroll new Medicare members, as well as any actions that we take in response to the sanction, will have a material negative affect on our results of operations and business in 2009 and potentially beyond. Further, there can be no assurance that we will be able to take appropriate corrective action or that, despite any corrective measures taken on our part, that we will not incur additional penalties, fines or other operating restrictions which could have an additional material adverse affect on our results of operations. Additionally, we are assessing the impact of ceasing marketing activities and the resulting loss of membership to determine what effect, if any, this action will have on our staffing needs and other operational capabilities or to scale our associate levels to effectively and efficiently meet the needs of the members we serve.

Some of our contracts are also subject to termination or are only eligible for renewal through annual competitive bidding processes. For example, renewal of our PDP business is subject to an annual bidding process. As previously described, we bid above the CMS benchmark in 22 of the 34 CMS regions for plan year 2009 and are ineligible to receive auto-assigned members in these regions. As a result, 252,000 auto-assigned dual-eligible members were assigned away from our plans and approximately 28,000 low-income subsidized members disenrolled from our plans on January 1, 2009. If we are unable to renew or to rebid or compete successfully for any of our existing or potential government contracts, if any of our contracts are terminated, or if any limitations or restrictions are imposed, our business, financial condition, results of operations and cash flows could be materially adversely affected.

Risks Related to Being a Regulated Entity

Reductions in funding for government health care programs could have a material adverse effect on our results of operations.

All of the health care services we offer are through government-sponsored programs, such as Medicaid and Medicare. As a result, our profitability is dependent, in large part, on continued funding for government health care programs at or above current levels. For example, the premium rates paid by each state to health plans like ours differ depending on a combination of factors such as upper payment limits established by the state and federal governments, a member s health status, age, gender, county or region, benefit mix and member eligibility categories. Future Medicaid premium rate levels may be affected by continued government efforts to contain medical costs or state and federal budgetary constraints. Some of the states in which we operate have experienced fiscal challenges leading to significant budget deficits. According to the National Association of State Budget Officers, Medicaid spending consumes approximately one-quarter of the average state s budget, representing the second largest expenditure. Health care spending increases appear to be more limited than in the past, states continue to look at Medicaid programs as opportunities for budget savings and some states may find it difficult to continue paying current rates to Medicaid health plans.

Changes in Medicaid funding may lead to reductions in the number of persons enrolled in or eligible for Medicaid, reductions in the amount of reimbursement or elimination of coverage for certain benefits such as pharmacy, behavioral health or other benefits. In some cases, changes in funding could be made retroactive, in which case we may be required to return premiums already received or receive reduced future payments. In the recent past, all of the states in which we operate have implemented or considered legislation or regulations that would reduce reimbursement rates, payment levels, benefits covered or the number of persons eligible for Medicaid. Reductions in Medicaid payments could reduce our profitability if we are unable to reduce our expenses at the same rate.

Further, continued economic slowdowns in our markets have negatively impacted state revenues. The number of persons eligible to receive Medicaid benefits may grow more slowly or even decline more rapidly or in tandem with declining economic conditions. For example, the governments that oversee the Medicaid programs could choose to limit program eligibility in an effort to reduce the portion of their respective state budgets attributable to Medicaid, which would cause our membership and revenues to decrease. Therefore, declining general economic conditions may cause our membership levels to decrease even further, which could have a material adverse effect on our results of operations. The states may also develop future Medicaid capitation rates that, while actuarially sound, are insufficient to keep pace with medical trends or inflation, therefore reducing our profitability in those markets and materially adversely affecting our results of operations.

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We are experiencing pressure on rates in Florida and Georgia, two states from which we derive a substantial portion of our revenue. In 2008 and 2009, Florida implemented Medicaid rates that were below our expectations and ultimately caused us to withdraw from the Medicaid reform program which will result in a loss of approximately 80,000 members. The withdrawal was originally to be effective May 1, 2009, but was subsequently changed to July 1, 2009. New legislation in Georgia related to payment of claims, eligibility determination and provider contracting, may negatively impact revenues and profits for the plan in 2009 and beyond. Further, continued economic slowdowns in Florida and Georgia could result in additional state actions that could adversely affect our revenues.

Similar to Medicaid, reductions in payments under Medicare or the other programs under which we offer health plans could likewise reduce our profitability. The MMA permits premium levels for certain Medicare plans to be established through competitive bidding, with Congress retaining the ability to limit increases in premium levels established through bidding from year to year. The federal government also has passed legislation that phases out Medicare Advantage budget neutrality payments through 2011, which impacts premium increases over that timeframe. The Congress is considering other reductions to rates or other changes to Medicare Part D which could also have a material adverse effect on our results of operations.

In January 2009, the new presidential administration took office. Although the new administration and recently elected U.S. Congress have expressed some support for measures intended to expand the number of citizens covered by health insurance and other changes within the health care system, the costs of implementing any of these proposals could be financed, in part, by reductions in the payments made to health care providers under Medicare and other government programs. In January 2009, the U.S. Congress approved the children s health bill which, among things, increases federal funding to S-CHIP. In addition, in February 2009, President Obama signed the American Recovery and Reinvestment Act that provides funding for, among other things: state Medicaid programs; the modernization of health information technology systems and aid to states to help defray budget cuts. Because of the unsettled nature of these initiatives and the numerous steps that are needed to implement them, we remain uncertain as to the ultimate impact these will have on us.

We are subject to periodic reviews and audits under our contracts with state government agencies, and these audits could have adverse findings which may have a material adverse effect on our business.

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

- forfeiture or recoupment of amounts we have been paid pursuant to our government contracts;
- imposition of significant civil or criminal penalties, fines or other sanctions on us and/or our key associates;
- loss of our right to participate in government-sponsored programs, including Medicaid and Medicare;
- damage to our reputation in various markets;
- increased difficulty in marketing our products and services;
- inability to obtain approval for future service or geographic expansion; and
- suspension or loss of one or more of our licenses to act as an insurer, HMO or third party administrator or to otherwise provide a service.

We are currently undergoing standard periodic audits by several Departments of Insurance and CMS to verify compliance with our contracts and applicable laws and regulations. In 2008, CMS completed its routine comprehensive audit of all of our Medicare operations. CMS s audit report indicates that we are deficient in a number of areas. We implemented corrective action plans to address CMS s findings, but in February 2009, as discussed above, we were notified by the CMS that, effective March 7, 2009, we were being sanctioned in the form of a suspension of marketing to Medicare beneficiaries and enrollment into all lines of our Medicare business. This

suspension will remain in effect until CMS determines that the suspension should be lifted. Among other areas, CMS s determination was based on findings of deficiencies in our enrollment and disenrollment operations, appeals and grievances, timely and proper responses to beneficiary complaints and requests for assistance and marketing and agent/broker oversight activities. We are

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working closely with CMS to address their concerns. At this time, we cannot provide any assurances regarding the duration of the suspension or the ultimate impact it will have on our results of operations and our business. Nonetheless, we anticipate that our inability to enroll new Medicare members will have a material negative affect on our results of operations and business in 2009 and potentially beyond. Further, we cannot provide any assurances that we will be able to take appropriate corrective action or that, despite any corrective measures taken on our part, that we will not incur additional penalties, fines or other operating restrictions which could have an additional material adverse effect on our results of operations.

If state regulatory agencies require a higher statutory capital level for our existing operations or if we become subject to additional capital requirements, we may be required to make additional capital contributions to our regulated subsidiaries, which would have a material adverse effect on our cash flows and liquidity.

Our operations are conducted through licensed HMO and insurance subsidiaries. These subsidiaries are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital and maintenance of certain financial ratios, as defined by each state. One or more of these states may raise the statutory capital level from time to time, which could have a material adverse effect on our cash flows and liquidity.

Our subsidiaries also may be required to maintain higher levels of statutory net worth due to the adoption of risk-based capital requirements by other states in which we operate. Our subsidiaries are subject to their state regulators general oversight powers. Regardless of whether a state adopts the risk-based capital requirements, the state s regulators can require our subsidiaries to maintain minimum levels of statutory net worth in excess of amounts required under the applicable state laws if they determine that maintaining such additional statutory net worth is in the best interests of our members. In addition, as we continue to expand our plan offerings in new states or pursue new business opportunities, we may be required to make additional statutory capital contributions. In either case, any additional capital contribution made to one or more of the affected subsidiaries could have a material adverse effect on our liquidity, cash flows and growth potential, which could harm our ability to implement our business strategy by, for example, hindering our ability to make debt service payments on amounts drawn from our credit facilities. In addition, increases of statutory capital requirements could cause us to withdraw from certain programs or markets where it becomes economically difficult to continue to be profitable. For example, we recently evaluated the capitalization requirement for our PFFS plans and determined that it was economically prudent to withdraw from participation in these plans in Texas, Florida and Wisconsin since the capital requirements for these states applied to the subsidiary as a whole, effectively increasing the capital requirements for several other states operating under the same license. If we restructure our insurance licenses for Florida, Texas and Wisconsin such that the capital requirements apply only to the business in those states, we may re-consider our interest in offering products in those states. Accordingly, effective January 1, 2009 we exited the PFFS business in these three states in which we provided services to approximately 10,000 members.

Additionally, one or more of our regulators could require one or more of our subsidiaries to maintain minimum levels of statutory net worth in excess of the amount required under the applicable state laws if the regulators were to determine that such a requirement were in the interest of our members. For example, a state regulator recently notified us that in its view, notwithstanding a parental guarantee that has been in place since 2006, two of our HMOs should contribute a total of approximately $30.0 million in additional statutory capital. We are currently discussing this request with the regulator.

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

Recent Sales of Unregistered Securities

During the quarterly period ended September 30, 2008, we sold the following securities in transactions that were not registered under the Securities Act of 1933, as amended (the Act):

On July 1, 2008, we issued 50,000 restricted shares of our common stock to Thomas L. Tran in connection with him being hired as our Senior Vice President and Chief Financial Officer. The issuance was made pursuant to the exemption provided under Section 4(2) of the Act, based on representations made by Mr. Tran. A nominal sum was paid by Mr. Tran to cover the par value of the shares.

On August 11, 2008, we issued 20,000 restricted shares of our common stock to Jonathan P. Rich in connection with him being hired as our Senior Vice President and Chief Compliance Officer. The issuance was made pursuant to the exemption provided under Section 4(2) of the Act, based on representations made by Mr. Rich. A nominal sum was paid by Mr. Rich to cover the par value of the shares.

On September 2, 2008, we issued 55,000 restricted shares of our common stock to Rex M. Adams in connection with him being hired as our Chief Operating Officer. The issuance was made pursuant to the exemption provided under Section 4(2) of the Act, based on representations made by Mr. Adams. A nominal sum was paid by Mr. Adams to cover the par value of the shares.

Issuer Purchases of Equity Securities

We do not have a stock repurchase program. However, during the quarter ended September 30, 2008, certain of our employees were deemed to have surrendered shares of our common stock to satisfy their withholding tax obligations associated with the vesting of shares of restricted common stock. The following table summarizes these repurchases:

Period	Total Number of Shares Purchased(1)	Average Price Paid Per Share(1)	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs
July 1, 2008 through July 31, 2008	19,271	$34.91 (2)	N/A	N/A
August 1, 2008 through August 31, 2008	4,457	$39.93 (3)	N/A	N/A
September 1, 2008 through September 30, 2008	2,230	$37.91 (4)	N/A	N/A
Total during quarter ended September 30, 2008	25,958	$37.09 (5)	N/A	N/A

(1) The number of shares purchased represent the number of shares of our common stock deemed surrendered by our employees to satisfy their withholding tax obligations due to the vesting of shares of restricted common stock. For the purposes of this table, we determined the

			average price paid per share based on the closing price of our common stock as of the date of the determination of the withholding tax amounts (i.e., the date that the shares of restricted stock vested). We do not currently have a stock repurchase program. We did not pay any cash consideration to repurchase these shares.

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(2) The weighted average price paid per share during the period was $35.94.

(3) The weighted average price paid per share during the period was $40.00.

(4) The weighted average price paid per share during the period was $38.86.

(5) The weighted average price paid per share during the period was $37.04.

Item 3. Defaults upon Senior Securities.

As previously disclosed and described in our 2007 10-K, our senior secured credit facility with Wachovia Bank, as Administrative Agent, and a syndicate of lenders, which has a term loan facility with an outstanding balance of approximately $152.8 million as of December 31, 2008, is currently in default and subject to acceleration by the lenders and, absent acceleration by the lenders, will become due and payable on May 13, 2009. Although we are not in payment default, we are in default of a number of covenants contained in the credit agreement (including our failure to provide the lenders with audited financial statements, our 2008 budget and other requested reports and information), some of which cannot be cured prior to maturity of the senior secured credit facility (such as our entry into intercompany loan transactions that were not effected in compliance with the credit agreement). As of the date hereof, our payment obligations under the credit agreement have not been accelerated and the rate of interest has not been increased. However, we cannot provide any assurance that such obligations will not be accelerated or the rate of interest increased in the future or that the lenders will not exercise other remedies for default.

Item 4. Submission of Matters to a Vote of Security Holders.

None.

Item 5. Other Information.

As previously reported in a Current Report on Form 8-K filed on February 4, 2009, we notified AHCA that we intended to terminate our Medicaid reform contract No. FAR001 (the HealthEase Reform Contract) dated June 26, 2006 between AHCA and HealthEase of Florida, Inc. (HealthEase), a wholly-owned subsidiary, and Medicaid reform contract No. FAR009 (together with the HealthEase Reform Contract, the Reform Contracts) dated June 26, 2006, between AHCA and WellCare of Florida, Inc. d/b/a StayWell Health Plan of Florida (WCFL), another wholly owned subsidiary. Under the Reform Contracts, HealthEase and WCFL provide health care programs in Duval and Broward counties to recipients of Temporary Assistance for Needy Families and Supplemental Security Income, as well as to

the HIV/AIDS specialty population. The termination of the Reform Contracts was to be effective May 1, 2009. However, on February 27, 2009, we agreed, by letter sent to AHCA, to extend the termination date to July 1, 2009.

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Item 6. Exhibits.

Exhibit List

Exhibit Number	Description	incorporated by reference Form	Filing Date with SEC	Exhibit Number
2.1	Agreement and Plan of Merger, dated as of February 12, 2004, between WellCare Holdings, LLC and WellCare Group, Inc.	S-1/A	June 8, 2004	2.1
3.1	Amended and Restated Certificate of Incorporation	10-Q	August 13, 2004	3.1
3.2	Amended and Restated Bylaws of WellCare Health Plans, Inc.	10-Q	August 13, 2004	3.2
3.2.1	Amendment No. 1 to the Amended and Restated Bylaws of WellCare Health Plans, Inc.	8-K	January 31, 2008	3.2
4.1	Specimen common stock certificate	S-1/A	June 29, 2004	4.1
10.1	Ohio Medical Assistance Provider Agreement for Managed Care Plan for CFC Eligible Population between the Ohio Department of Job and Family Services and WellCare of Ohio, Inc.	8-K	July 3, 2008	10.1
10.2	Employment Agreement by and among Thomas L. Tran, WellCare Health Plans, Inc. and Comprehensive Health Management, Inc.	8-K	July 17, 2008	10.1
10.3	Indemnification Agreement between Thomas L. Tran and WellCare Health Plans, Inc.	8-K	July 17, 2008	10.2
10.4	Form of Restricted Stock Agreement between Thomas L. Tran and WellCare Health Plans, Inc.	8-K	July 17, 2008	10.3
10.5	Form of Non-Qualified Stock Option Agreement between Thomas L. Tran and WellCare Health Plans, Inc.	8-K	July 17, 2008	10.4
10.6	Amendment number 3 to Medicaid Advantage Model Contract No. C021236, between the New York	8-K	July 17, 2008	10.1

	State Department of Health and WellCare of New York, Inc.			
10.7	Amendment number 9 to Missouri HealthNet Managed Care Eastern Region contract between the State of Missouri Office of Administration Division of Purchasing and Materials Management and Harmony Health Plan of Illinois, Inc. d/b/a Harmony Health Plan of Missouri.	8-K	July 17, 2008	10.2
10.8	Employment Agreement by and among Jonathan P. Rich, WellCare Health Plans, Inc. and Comprehensive Health Management, Inc.	8-K	August 13, 2008	10.1
10.9	Indemnification Agreement between Jonathan P. Rich and WellCare Health Plans, Inc. (incorporated by reference to the Company s form indemnification agreement filed as Exhibit 10.24 to the Company s Form S-1/A filed on June 8, 2004)	8-K	April 13, 2008	10.2
10.10	Form of Restricted Stock Agreement between Jonathan P. Rich and WellCare Health Plans, Inc.	8-K	August 13, 2008	10.3
10.11	Form of Non Qualified Stock Option Agreement between Jonathan	8-K	August 13, 2008	10.4

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	P. Rich and WellCare Health Plans, Inc.			
10.12	Agreement, by and among WellCare Health Plans, Inc., the United States Attorney s Office for the Middle District of Florida, the Agency for Health Care Administration and the Florida Attorney General s Medicaid Fraud Control Unit, dated as of August 18, 2008.	8-K	August 18, 2008	10.1
10.13	Medical Services Agreement between the Florida Healthy Kids Corporation and HealthEase of Florida, Inc. and WellCare of Florida, Inc. (f/k/a Well Care HMO, Inc.) d/b/a Staywell Health Plan of Florida.	8-K	August 20, 2008	10.1
10.14	Employment Agreement by and among Rex M. Adams, WellCare Health Plans, Inc. and Comprehensive Health Management, Inc.	8-K	September 2, 2008	10.1
10.15	Indemnification Agreement between Rex M. Adams and WellCare Health Plans, Inc. (incorporated by reference to the Company s form indemnification agreement filed as Exhibit 10.24 to the Company s Form S-1/A filed on June 8, 2004)	8-K	September 2, 2008	10.2
10.16	Restricted Stock Agreement between Rex M. Adams and WellCare Health Plans, Inc.	8-K	September 2, 2008	10.3
10.17	Non Qualified Stock Option Agreement between Rex M. Adams and WellCare Health Plans, Inc.	8-K	September 2, 2008	10.4
10.18	Amendment to Medicaid Advantage Model Contract between the New York City Department of Health and Mental Hygiene and WellCare of New York, Inc.	8-K	September 11, 2008	10.1

10.19	Amendment number 9 to Contract No. FAR001, dated June 26, 2006, between the State of Florida, Agency for Health Care Administration and HealthEase Health Plan of Florida, Inc. (Medicaid Reform 2006-2009)	8-K	September 12, 2008	10.1
10.20	Amendment number 10 to Contract No. FAR001, dated June 26, 2006, between the State of Florida, Agency for Health Care Administration and HealthEase Health Plan of Florida, Inc. (Medicaid Reform 2006-2009)	8-K	September 12, 2008	10.2
10.21	Amendment number 9 to Contract No. FAR009, dated June 26, 2006, between the State of Florida, Agency for Health Care Administration and WellCare of Florida, Inc. d/b/a Staywell Health Plan of Florida (Medicaid Reform 2006-2009)	8-K	September 12, 2008	10.3
10.22	Amendment number 10 to Contract No. FAR009, dated June 26, 2006, between the State of Florida, Agency for Health Care Administration and WellCare of Florida, Inc. d/b/a Staywell Health Plan of Florida (Medicaid Reform 2006-2009)	8-K	September 12, 2008	10.4
10.23	Amendment number 6 to Contract No. FA615, dated September 1, 2006, between the State of Florida, Agency for Health Care Administration and WellCare of Florida, Inc. d/b/a Staywell Health Plan of Florida (Medicaid Non-Reform Contract 2006-2009)	8-K	September 12, 2008	10.5
10.24	Amendment number 7 to Contract No. FA615, dated September 1, 2006, between the State of Florida, Agency for Health Care Administration and WellCare of Florida, Inc. d/b/a Staywell Health	8-K	September 12, 2008	10.6

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	Plan of Florida (Medicaid Non-Reform Contract 2006-2009)			
10.25	Amendment number 5 to Contract No. FA619, dated September 1, 2006, between the State of Florida, Agency for Health Care Administration and HealthEase of Florida, Inc. (Medicaid Non-Reform Contract 2006-2009)	8-K	September 12, 2008	10.7
10.26	Renewal Notice regarding Contract S5967 between the Centers for Medicare and Medicaid Services and WellCare Prescription Insurance, Inc. with Addendum	8-K	September 29, 2008	10.1
10.27	Letter Agreement to Anil Kottoor, dated July 2, 2008*			
31.1	Certification of President and Chief Executive Officer pursuant to Section 302 of Sarbanes-Oxley Act of 2002*			
31.2	Certification of Chief Financial Officer pursuant to Section 302 of Sarbanes-Oxley Act of 2002*			
32.1	Certification of President and Chief Executive Officer pursuant to Section 906 of Sarbanes-Oxley Act of 2002*			
32.2	Certification of Chief Financial Officer pursuant to Section 906 of Sarbanes-Oxley Act of 2002*			

* Filed herewith

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SIGNATURES

Pursuant to the requirements of the Securities and Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized in Tampa, Florida on March 2, 2009.

WELLCARE HEALTH PLANS, INC.

By: /s/ Heath Schiesser
Heath Schiesser
President and Chief Executive Officer

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

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