MAGELLAN HEALTH SERVICES INC
Form 10-Q
July 27, 2012

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-Q

(Mark One)

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

For the Quarterly Period Ended June 30, 2012

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 No. 1-6639

MAGELLAN HEALTH SERVICES, INC.

(Exact name of registrant as specified in its charter)

Delaware	**58-1076937**
(State or other jurisdiction of incorporation or organization)	(IRS Employer Identification No.)
55 Nod Road, Avon, Connecticut	**06001**
(Address of principal executive offices)	(Zip code)

(860) 507-1900
(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 twelve 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 ý No o

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

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

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

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

The number of shares of the registrant's Ordinary Common Stock outstanding as of June 30, 2012 was 27,359,021.

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PART I FINANCIAL INFORMATION

Item 1. Financial Statements.

MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

(In thousands, except per share amounts)

	December 31, 2011	June 30, 2012 (unaudited)
ASSETS		
Current Assets:		
Cash and cash equivalents	$ 119,862	$ 168,020
Restricted cash	185,794	208,639
Accounts receivable, less allowance for doubtful accounts of $3,336 and $3,877 at December 31, 2011 and June 30, 2012, respectively	121,606	120,178
Short-term investments (restricted investments of $129,599 and $109,119 at December 31, 2011 and June 30, 2012, respectively)	192,947	180,630
Deferred income taxes	35,138	34,926
Pharmaceutical inventory	39,567	38,354
Other current assets (restricted deposits of $20,453 and $22,055 at December 31, 2011 and June 30, 2012, respectively)	37,795	42,804
Total Current Assets	732,709	793,551
Property and equipment, net	118,022	129,800
Restricted long-term investments	7,956	8,962
Other long-term assets	10,952	9,738
Goodwill	426,939	426,939
Other intangible assets, net	44,589	39,714
Total Assets	$ 1,341,167	$ 1,408,704
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current Liabilities:		
Accounts payable	$ 18,690	$ 17,564
Accrued liabilities	106,809	87,913
Medical claims payable	137,973	181,791
Other medical liabilities	106,078	82,468
Total Current Liabilities	369,550	369,736
Deferred income taxes	18,509	24,399
Tax contingencies	102,919	105,259
Deferred credits and other long-term liabilities	4,915	4,602
Total Liabilities	495,893	503,996
Preferred stock, par value $.01 per share		
Authorized 10,000 shares Issued and outstanding none		
Ordinary common stock, par value $.01 per share		
Authorized 100,000 shares at December 31, 2011 and June 30, 2012 Issued and outstanding 45,285 shares and 27,173 shares at December 31, 2011, respectively, and 45,471 and 27,359 shares at June 30, 2012, respectively	453	455
Multi-Vote common stock, par value $.01 per share		
Authorized 40,000 shares Issued and outstanding none		
Other Stockholders' Equity:		
Additional paid-in capital	804,035	815,616
Retained earnings	824,205	871,968

Accumulated other comprehensive loss		(150)		(62)
Ordinary common stock in treasury, at cost, 18,112 shares and 18,112 shares at December 31, 2011 and June 30, 2012, respectively		(783,269)		(783,269)
Total Stockholders' Equity		845,274		904,708
Total Liabilities and Stockholders' Equity	$	1,341,167	$	1,408,704

See accompanying notes to consolidated financial statements.

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MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

(Unaudited)

(In thousands, except per share amounts)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	**2012**	**2011**	**2012**
Net revenue	$ 698,338	$ 805,473	$ 1,391,093	$ 1,578,686
Cost and expenses:				
Cost of care	441,446	521,830	875,146	1,027,123
Cost of goods sold	53,404	82,855	109,923	163,893
Direct service costs and other operating expenses(1)	131,779	140,333	263,346	276,922
Depreciation and amortization	14,267	15,152	28,219	29,933
Interest expense	494	576	965	1,176
Interest income	(858)	(857)	(1,673)	(1,269)
	640,532	759,889	1,275,926	1,497,778
Income before income taxes	57,806	45,584	115,167	80,908
Provision for income taxes	23,575	18,611	46,638	33,145
Net income	34,231	26,973	68,529	47,763
Net income per common share basic (See Note B)	$ 1.09	$ 0.99	$ 2.13	$ 1.75
Net income per common share diluted (See Note B)	$ 1.07	$ 0.97	$ 2.09	$ 1.72
Other comprehensive income				
Unrealized (losses) gains on available-for-sale securities(2)	(19)	(85)	78	88
Comprehensive income	$ 34,212	$ 26,888	$ 68,607	$ 47,851

(1) Includes stock compensation expense of $4,205 and $4,365 for the three months ended June 30, 2011 and 2012, respectively, and $8,983 and $9,467 for the six months ended June 30, 2011 and 2012, respectively.

(2) Net of income tax provision (benefit) of $(12) and $(55) for the three months ended June 30, 2011 and 2012, respectively, and $49 and $56 for the six months ended June 30, 2011 and 2012, respectively.

See accompanying notes to consolidated financial statements.

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MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

FOR THE SIX MONTHS ENDED JUNE 30,

(Unaudited)

(In thousands)

	2011	2012
Cash flows from operating activities:		
Net income	$ 68,529	$ 47,763
Adjustments to reconcile net income to net cash (used in) provided by operating activities:		
Depreciation and amortization	28,219	29,933
Non-cash interest expense	213	360
Non-cash stock compensation expense	8,983	9,467
Non-cash income tax expense	6,885	7,143
Non-cash amortization on investments	6,648	3,720
Cash flows from changes in assets and liabilities, net of effects from acquisitions of businesses:		
Restricted cash	13,697	(22,845)
Accounts receivable, net	(77,031)	1,428
Pharmaceutical inventory	(17,117)	1,213
Other assets	(4,024)	(3,066)
Accounts payable and accrued liabilities	(27,098)	(20,022)
Medical claims payable and other medical liabilities	(12,390)	20,208
Other	2,598	(270)
Net cash (used in) provided by operating activities	(1,888)	75,032
Cash flows from investing activities:		
Capital expenditures	(26,693)	(36,877)
Acquisitions and investments in businesses, net of cash acquired	(274)	
Purchase of investments	(187,807)	(143,155)
Maturity of investments	123,043	150,890
Net cash used in investing activities	(91,731)	(29,142)
Cash flows from financing activities:		
Payments to acquire treasury stock	(211,451)	
Proceeds from issuance of equity	20,000	
Proceeds from exercise of stock options and warrants	28,842	3,003
Other	391	(735)
Net cash (used in) provided by financing activities	(162,218)	2,268
Net (decrease) increase in cash and cash equivalents	(255,837)	48,158
Cash and cash equivalents at beginning of period	337,179	119,862
Cash and cash equivalents at end of period	$ 81,342	$ 168,020

See accompanying notes to consolidated financial statements.

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MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

June 30, 2012

(Unaudited)

NOTE A General

Basis of Presentation

The accompanying unaudited consolidated financial statements of Magellan Health Services, Inc., a Delaware corporation ("Magellan"), include the accounts of Magellan, its majority owned subsidiaries, and all variable interest entities ("VIEs") for which Magellan is the primary beneficiary (together with Magellan, the "Company"). The financial statements have been prepared in accordance with accounting principles generally accepted in the United States for interim financial information and with the Securities and Exchange Commission's (the "SEC") instructions to Form 10-Q. Accordingly, the financial statements do not include all of the information and footnotes required by accounting principles generally accepted in the United States for complete financial statements. In the opinion of management, all adjustments, consisting of normal recurring adjustments considered necessary for a fair presentation, have been included. The results of operations for the three months and six months ended June 30, 2012 are not necessarily indicative of the results to be expected for the full year. All significant intercompany accounts and transactions have been eliminated in consolidation.

The Company has evaluated subsequent events for recognition or disclosure in our consolidated financial statements filed on this Form 10-Q and no events have occurred that require disclosure.

These unaudited consolidated financial statements should be read in conjunction with the Company's audited consolidated financial statements for the year ended December 31, 2011 and the notes thereto, which are included in the Company's Annual Report on Form 10-K filed with the SEC on February 28, 2012.

Business Overview

The Company is engaged in the specialty managed healthcare business. Through 2005, the Company predominantly operated in the managed behavioral healthcare business. As a result of certain acquisitions, the Company expanded into radiology benefits management and specialty pharmaceutical management during 2006, and into Medicaid administration during 2009. The Company provides services to health plans, insurance companies, employers, labor unions and various governmental agencies. The Company's business is divided into the following six segments, based on the services it provides and/or the customers that it serves, as described below.

Managed Behavioral Healthcare

Two of the Company's segments are in the managed behavioral healthcare business. This line of business generally reflects the Company's coordination and management of the delivery of behavioral healthcare treatment services that are provided through its contracted network of third-party treatment providers, which includes psychiatrists, psychologists, other behavioral health professionals, psychiatric hospitals, general medical facilities with psychiatric beds, residential treatment centers and other treatment facilities. The treatment services provided through the Company's provider network include outpatient programs (such as counseling or therapy), intermediate care programs (such as intensive outpatient programs and partial hospitalization services), inpatient treatment and crisis intervention services. The Company generally does not directly provide or own any provider of treatment services.

MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

June 30, 2012

(Unaudited)

NOTE A General (Continued)

The Company provides its management services primarily through: (i) risk-based products, where the Company assumes all or a substantial portion of the responsibility for the cost of providing treatment services in exchange for a fixed per member per month fee, (ii) administrative services only ("ASO") products, where the Company provides services such as utilization review, claims administration and/or provider network management, but does not assume responsibility for the cost of the treatment services, and (iii) employee assistance programs ("EAPs") where the Company provides short-term outpatient behavioral counseling services.

The managed behavioral healthcare business is managed based on the services provided and/or the customers served, through the following two segments:

Commercial. The Managed Behavioral Healthcare Commercial segment ("Commercial") generally reflects managed behavioral healthcare services and EAP services provided under contracts with health plans and insurance companies for some or all of their commercial, Medicaid and Medicare members, as well as with employers, including corporations, governmental agencies, and labor unions. Commercial's contracts encompass risk-based, ASO and EAP arrangements.

Public Sector. The Managed Behavioral Healthcare Public Sector segment ("Public Sector") generally reflects services provided to recipients under Medicaid and other state sponsored programs under contracts with state and local governmental agencies. Public Sector contracts encompass either risk-based or ASO arrangements.

Radiology Benefits Management

The Radiology Benefits Management segment ("Radiology Benefits Management") generally reflects the management of the delivery of diagnostic imaging and other therapeutic services to ensure that such services are clinically appropriate and cost effective. The Company's radiology benefits management services currently are provided under contracts with health plans and insurance companies for some or all of their commercial, Medicaid and Medicare members. The Company also contracts with state and local governmental agencies for the provision of such services to Medicaid recipients. The Company offers its radiology benefits management services through risk-based contracts, where the Company assumes all or a substantial portion of the responsibility for the cost of providing diagnostic imaging services, and through ASO contracts, where the Company provides services such as utilization review and claims administration, but does not assume responsibility for the cost of the imaging services.

Drug Benefits Management

Two of the Company's segments are in the drug benefits management business. This line of business generally reflects the Company's clinical management of drugs paid under medical and pharmacy benefit programs. The Company's services include the coordination and management of the specialty drug spending for health plans, employers, and governmental agencies, and the management

MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

June 30, 2012

(Unaudited)

NOTE A General (Continued)

of pharmacy programs for Medicaid and other state-sponsored programs. The two segments in this line of business are:

Specialty Pharmaceutical Management. The Specialty Pharmaceutical Management segment ("Specialty Pharmaceutical Management") comprises programs that manage specialty drugs used in the treatment of complex conditions such as cancer, multiple sclerosis, hemophilia, infertility, rheumatoid arthritis, chronic forms of hepatitis and other diseases. Specialty pharmaceutical drugs represent high-cost injectible, infused, or oral drugs with sensitive handling or storage needs, many of which may be physician administered. Patients receiving these drugs require greater amounts of clinical support than those taking more traditional agents. Payors require clinical, financial and technological support to maximize the value delivered to their members using these expensive agents. The Company's specialty pharmaceutical management services are provided under contracts with health plans, insurance companies, employers, and governmental agencies for some or all of their commercial, Medicare and Medicaid members. The Company's specialty pharmaceutical services include: (i) contracting and formulary optimization programs; (ii) specialty pharmaceutical dispensing operations; and (iii) medical pharmacy management programs.

Medicaid Administration. The Medicaid Administration segment ("Medicaid Administration") generally reflects integrated clinical management services provided to the public sector to manage Medicaid pharmacy, mental health, and long-term care programs. The primary focus of the Company's Medicaid Administration unit involves providing pharmacy benefits administration ("PBA") and pharmacy benefits management ("PBM") services under contracts with health plans and public sector healthcare clients for Medicaid and other state sponsored program recipients. The Company's services include pharmacy point-of-sale claims processing systems and administration, drug utilization review, clinical prior authorization, utilization and formulary management services, Preferred Drug List programs, Maximum Allowable Cost programs, and drug rebate program services. Medicaid Administration's contracts encompass Fee-For-Service ("FFS") arrangements. In addition to Medicaid Administration's FFS contracts, effective September 1, 2010, Public Sector has subcontracted with Medicaid Administration to provide pharmacy benefits management services on a risk basis for one of Public Sector's customers.

Corporate

This segment of the Company is comprised primarily of operational support functions such as sales and marketing and information technology, as well as corporate support functions such as executive, finance, human resources and legal.

Summary of Significant Accounting Policies

Recent Accounting Pronouncements

In May 2011, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2011-04, "Fair Value Measurement (Topic 820): Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRSs", ("ASU 2011-04"). ASU 2011-04 amends ASC Topic 820, "Fair Value Measurements and Disclosures", to

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MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

June 30, 2012

(Unaudited)

NOTE A General (Continued)

provide guidance on how fair value measurement should be applied where existing GAAP already requires or permits fair value measurements. In addition, ASU 2011-04 requires expanded disclosures regarding fair value measurements. ASU 2011-04 became effective for the Company on January 1, 2012. The adoption of ASU 2011-04 did not have a material impact on the Company's results of operations or financial position.

In June 2011, the FASB issued ASU No. 2011-05, "Comprehensive Income (Topic 220): Presentation of Comprehensive Income" ("ASU 2011-05"). ASU 2011-05 requires an entity to present the total of comprehensive income, the components of net income, and the components of other comprehensive income either in a single continuous statement of comprehensive income or in two separate but consecutive statements and eliminates the option to present the components of other comprehensive income as part of the statement of equity. ASU 2011-05 became effective for the Company on January 1, 2012. While the adoption of this guidance impacts the Company's disclosures for annual and interim filings for the year ending December 31, 2012, it does not impact the Company's results of operations or financial position.

In September 2011, the FASB issued ASU 2011-08, "Testing Goodwill for Impairment" ("ASU 2011-8"), which provides authoritative guidance to simplify how entities, both public and nonpublic, test goodwill for impairment. This accounting update permits an entity to first assess qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount as a basis for determining whether it is necessary to perform the two-step goodwill impairment test. This guidance was effective for the Company beginning on January 1, 2012. This guidance did not impact the Company's financial position, results of operations or cash flows.

In December 2011, the FASB issued ASU 2011-12 "Deferral of the Effective Date for Amendments to the Presentation of Reclassifications of Items Out of Accumulated Other Comprehensive Income in ASU 2011-05" ("ASU 2011-12"), which defers the requirement that companies present reclassification adjustments for each component of accumulated other comprehensive income in both net income and other comprehensive income on the face of the financial statements. The effective dates for ASU 2011-12 are consistent with the effective dates for ASU 2011-05 and, similar to our expectations for the adoption of ASU 2011-05, while the adoption of this guidance impacts the Company's disclosures for annual and interim filings for the year ending December 31, 2012, it does not impact the Company's results of operations or financial position.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates of the Company include, among other things, accounts receivable realization, valuation allowances for deferred tax assets, valuation of goodwill and intangible assets, medical claims payable, other medical liabilities, stock compensation assumptions, tax contingencies and legal liabilities. Actual results could differ from those estimates.

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MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

June 30, 2012

(Unaudited)

NOTE A General (Continued)

Managed Care Revenue

Managed care revenue, inclusive of revenue from the Company's risk, EAP and ASO contracts, is recognized over the applicable coverage period on a per member basis for covered members. The Company is paid a per member fee for all enrolled members, and this fee is recorded as revenue in the month in which members are entitled to service. The Company adjusts its revenue for retroactive membership terminations, additions and other changes, when such adjustments are identified, with the exception of retroactivity that can be reasonably estimated. The impact of retroactive rate amendments is generally recorded in the accounting period that terms to the amendment are finalized, and that the amendment is executed. Any fees paid prior to the month of service are recorded as deferred revenue. Managed care revenues approximated $544.6 million and $1,094.6 million for the three and six months ended June 30, 2011, respectively, and $638.0 million and $1,239.8 million for the three and six months ended June 30, 2012, respectively.

Fee-For-Service and Cost-Plus Contracts

The Company has certain FFS contracts, including cost-plus contracts, with customers under which the Company recognizes revenue as services are performed and as costs are incurred. Revenues from fee-for-service and cost-plus contracts approximated $44.0 million and $86.4 million for the three and six months ended June 30, 2011, respectively, and $35.1 million and $71.0 million for the three and six months ended June 30, 2012, respectively.

Block Grant Revenues

Public Sector has a contract that is partially funded by federal, state and county block grant money, which represents annual appropriations. The Company recognizes revenue from block grant activity ratably over the period to which the block grant funding applies. Block grant revenues were approximately $27.0 million and $53.2 million for the three and six months ended June 30, 2011, respectively, and $29.0 million and $57.9 million for the three and six months ended June 30, 2012, respectively.

Dispensing Revenue

The Company recognizes dispensing revenue, which includes the co-payments received from members of the health plans the Company serves, when the specialty pharmaceutical drugs are shipped. At the time of shipment, the earnings process is complete; the obligation of the Company's customer to pay for the specialty pharmaceutical drugs is fixed, and, due to the nature of the product, the member may neither return the specialty pharmaceutical drugs nor receive a refund. Revenues from the dispensing of specialty pharmaceutical drugs on behalf of health plans were $56.6 million and $117.0 million for the three and six months ended June 30, 2011, respectively, and $88.5 million and $175.6 million for the three and six months ended June 30, 2012, respectively.

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MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

June 30, 2012

(Unaudited)

NOTE A General (Continued)

Performance-Based Revenue

The Company has the ability to earn performance-based revenue under certain risk and non-risk contracts. Performance-based revenue generally is based on either the ability of the Company to manage care for its clients below specified targets, or on other operating metrics. For each such contract, the Company estimates and records performance-based revenue after considering the relevant contractual terms and the data available for the performance-based revenue calculation. Pro-rata performance-based revenue is recognized on an interim basis pursuant to the rights and obligations of each party upon termination of the contracts. Performance-based revenues were $10.2 million and $13.2 million for the three and six months ended June 30, 2011, respectively, and $3.9 million and $11.9 million for the three and six months ended June 30, 2012, respectively.

Rebate Revenue

The Company administers a rebate program for certain clients through which the Company coordinates the achievement, calculation and collection of rebates and administrative fees from pharmaceutical manufacturers on behalf of clients. Each period, the Company estimates the total rebates earned based on actual volumes of pharmaceutical purchases by the Company's clients, as well as historical and/or anticipated sharing percentages. The Company earns fees based upon the volume of rebates generated for its clients. The Company does not record as rebate revenue any rebates that are passed through to its clients. Total rebate revenues were $7.8 million and $14.7 million for the three months and six months ended June 30, 2011, respectively, and $9.3 million and $19.0 million for the three months and six months ended June 30, 2012, respectively.

Significant Customers

Consolidated Company

The Company provides behavioral healthcare management and other related services to approximately 715,000 members in Maricopa County, Arizona, the ("Maricopa Contract").

Under the Maricopa Contract, the Company is responsible for providing covered behavioral health services to persons eligible under Title XIX (Medicaid) and Title XXI (State Children's Health Insurance Program) of the Social Security Act, non-Title XIX and non-Title XXI eligible children and adults with a serious mental illness, and to certain non-Title XIX and non-Title XXI adults with behavioral health or substance abuse disorders. The Maricopa Contract began on September 1, 2007 and extends through September 30, 2013 unless sooner terminated by the parties. The State of Arizona has the right to terminate the Maricopa Contract for cause, as defined, upon ten days' notice with an opportunity to cure, and without cause immediately upon notice from the State. The Maricopa Contract generated net revenues of $383.6 million and $383.2 million for the six months ended June 30, 2011 and 2012, respectively.

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MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

June 30, 2012

(Unaudited)

NOTE A General (Continued)

By Segment

In addition to the Maricopa Contract previously discussed, the following customers generated in excess of ten percent of net revenues for the respective segment for the six months ended June 30, 2011 and 2012 (in thousands):

Segment	Term Date	2011	2012
Commercial			
Customer A	December 31, 2013	$ 91,606	$ 96,106
Customer B	June 30, 2014	33,402	32,137*
Customer C	December 31, 2012 to December 14, 2013(1)	54,796	60,923
Customer D	December 31, 2019		67,381
Public Sector			
Customer E	June 30, 2013(2)	81,060	111,259
Radiology Benefits Management			
Customer F	December 31, 2015	67,392	53,405
Customer G	June 30, 2011 to November 30, 2011(1)(3)	30,934	
Customer H	June 30, 2014	26,720	29,049
Customer I	March 31, 2013	16,157*	28,092
Customer J	January 31, 2014	15,801*	18,333
Specialty Pharmaceutical Management			
Customer K	November 30, 2012 to December 31, 2013(1)	42,989	64,651
Customer L	September 1, 2012 to April 29, 2013(1)	27,963	30,643
Customer B	December 31, 2012 to September 27, 2013(1)	9,733*	33,746
Medicaid Administration			
Customer M	December 4, 2011(3)	13,805	
Customer N	September 30, 2013(4)	40,774	37,826
Customer O	March 31, 2015 to June 30, 2017(1)	12,466	12,880
Customer P	June 30, 2013 to September 30, 2014(1)	11,411	9,879

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*
Revenue amount did not exceed ten percent of net revenues for the respective segment for the period presented. Amount is shown for comparative purposes only.

(1)

The customer has more than one contract. The individual contracts are scheduled to terminate at various points during the time period indicated above.

(2) Contract has options for the customer to extend the term for two additional one-year periods.

(3) The contract has terminated.

(4) This customer represents a subcontract with a Public Sector customer and is eliminated in consolidation.

MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

June 30, 2012

(Unaudited)

NOTE A General (Continued)

Concentration of Business

The Company also has a significant concentration of business with various counties in the State of Pennsylvania (the "Pennsylvania Counties") which are part of the Pennsylvania Medicaid program, and with various areas in the State of Florida (the "Florida Areas") which are part of the Florida Medicaid program. Net revenues from the Pennsylvania Counties in the aggregate totaled $178.2 million and $182.4 million for the six months ended June 30, 2011 and 2012, respectively. Net revenues from the Florida Areas in the aggregate totaled $67.2 million and $67.7 million for the six months ended June 30, 2011 and 2012, respectively.

The Company's contracts with customers typically have terms of one to three years, and in certain cases contain renewal provisions (at the customer's option) for successive terms of between one and two years (unless terminated earlier). Substantially all of these contracts may be immediately terminated with cause and many of the Company's contracts are terminable without cause by the customer or the Company either upon the giving of requisite notice and the passage of a specified period of time (typically between 60 and 180 days) or upon the occurrence of other specified events. In addition, the Company's contracts with federal, state and local governmental agencies generally are conditioned on legislative appropriations. These contracts generally can be terminated or modified by the customer if such appropriations are not made.

Fair Value Measurements

The Company currently does not have non-financial assets and non-financial liabilities that are required to be measured at fair value on a recurring basis. Financial assets and liabilities are to be measured using inputs from the three levels of the fair value hierarchy, which are as follows:

Level 1 Inputs are unadjusted quoted prices in active markets for identical assets or liabilities that the Company has the ability to access at the measurement date.

Level 2 Inputs include quoted prices for similar assets and liabilities in active markets, quoted prices for identical or similar assets or liabilities in markets that are not active, inputs other than quoted prices that are observable for the asset or liability (i.e., interest rates, yield curves, etc.), and inputs that are derived principally from or corroborated by observable market data by correlation or other means (market corroborated inputs).

Level 3 Unobservable inputs that reflect the Company's assumptions about the assumptions that market participants would use in pricing the asset or liability. The Company develops these inputs based on the best information available, including the Company's data.

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MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

June 30, 2012

(Unaudited)

NOTE A General (Continued)

In accordance with the fair value hierarchy described above, the following table shows the fair value of the Company's financial assets and liabilities that are required to be measured at fair value as of December 31, 2011 and June 30, 2012 (in thousands):

	December 31, 2011			
	Level 1	Level 2	Level 3	Total
Cash and Cash Equivalents(1)	$	$ 1,296	$	$ 1,296
Restricted Cash(2)		47,972		47,972
Investments:				
U.S. Government and agency securities	697			697
Obligations of government-sponsored enterprises(3)		8,293		8,293
Corporate debt securities		191,813		191,813
Taxable municipal bonds				
Certificates of deposit		100		100
December 31, 2011	$ 697	$ 249,474	$	$ 250,171

	June 30, 2012			
	Level 1	Level 2	Level 3	Total
Cash and Cash Equivalents(4)	$	$ 633	$	$ 633
Restricted Cash(5)		66,779		66,779
Investments:				
U.S. Government and agency securities	536			536
Obligations of government-sponsored enterprises(3)		8,130		8,130
Corporate debt securities		171,214		171,214
Taxable municipal bonds		9,562		9,562
Certificates of deposit		150		150
June 30, 2012	$ 536	$ 256,468	$	$ 257,004

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(1) Excludes $118.6 million of cash held in bank accounts by the Company.

(2) Excludes $137.8 million of restricted cash held in bank accounts by the Company.

(3) Includes investments in notes issued by the Federal Home Loan Bank.

(4) Excludes $167.4 million of cash held in bank accounts by the Company.

(5) Excludes $141.8 million of restricted cash held in bank accounts by the Company.

For the six months ended June 30, 2012, the Company has not transferred any assets between fair value measurement levels.

All of the Company's investments are classified as "available-for-sale" and are carried at fair value.

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MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

June 30, 2012

(Unaudited)

NOTE A General (Continued)

If a debt security is in an unrealized loss position and the Company has the intent to sell the debt security, or it is more likely than not that the Company will have to sell the debt security before recovery of its amortized cost basis, the decline in value is deemed to be other-than-temporary and is recorded to other-than-temporary impairment losses recognized in income in the consolidated statements of comprehensive income. For impaired debt securities that the Company does not intend to sell or it is more likely than not that the Company will not have to sell such securities, but the Company expects that it will not fully recover the amortized cost basis, the credit component of the other-than-temporary impairment is recognized in other-than-temporary impairment losses recognized in income in the consolidated statements of comprehensive income and the non-credit component of the other-than-temporary impairment is recognized in other comprehensive income.

As of December 31, 2011 and June 30, 2012, there were no unrealized losses that the Company believed to be other-than-temporary. No realized gains or losses were recorded for the six months ended June 30, 2011 or 2012. The following is a summary of short-term and long-term investments at December 31, 2011 and June 30, 2012 (in thousands):

	December 31, 2011			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U.S. Government and agency securities	$ 697	$	$	$ 697
Obligations of government-sponsored enterprises(1)	8,293	3	(3)	8,293
Corporate debt securities	192,059	31	(277)	191,813
Certificates of deposit	100			100
Total investments at December 31, 2011	$ 201,149	$ 34	$ (280)	$ 200,903

	June 30, 2012			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
U.S. Government and agency securities	$ 536	$	$	$ 536
Obligations of government-sponsored enterprises(1)	8,127	3		8,130
Corporate debt securities	171,313	62	(161)	171,214
Certificates of deposit	150			150
Taxable municipal bonds	9,567		(5)	9,562
Total investments at June 30, 2012	$ 189,693	$ 65	$ (166)	$ 189,592

(1) Includes investments in notes issued by the Federal Home Loan Bank.

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MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

June 30, 2012

(Unaudited)

NOTE A General (Continued)

The maturity dates of the Company's investments as of June 30, 2012 are summarized below (in thousands):

	Amortized Cost	Estimated Fair Value
2012	$ 116,533	$ 116,517
2013	68,078	68,020
2014	5,082	5,055
Total investments at June 30, 2012	$ 189,693	$ 189,592

Income Taxes

The Company's effective income tax rates were 40.5 percent and 41.0 percent for the six months ended June 30, 2011 and 2012, respectively. These rates differ from the federal statutory income tax rate primarily due to state income taxes and permanent differences between book and tax income. The Company also accrues interest and penalties related to unrecognized tax benefits in its provision for income taxes. The effective income tax rate for the six months ended June 30, 2012 is higher than the effective rate for the six months ended June 30, 2011 mainly due to an increase in effective state tax rates.

Stock Compensation

At December 31, 2011 and June 30, 2012, the Company had equity-based employee incentive plans, which are described more fully in Note 6 in the Company's Annual Report on Form 10-K for the year ended December 31, 2011. The Company recorded stock compensation expense of $4.2 million and $9.0 million for the three and six months ended June 30, 2011, respectively, and $4.4 million and $9.5 million for the three and six months ended June 30, 2012, respectively. Stock compensation expense recognized in the consolidated statements of comprehensive income for the three and six months ended June 30, 2011 and 2012 has been reduced for estimated forfeitures, estimated at four percent for both periods.

The weighted average grant date fair value of all stock options granted during the six months ended June 30, 2012 was $11.80 as estimated using the Black-Scholes-Merton option pricing model, which also assumed an expected volatility of 30.3 percent based on the historical volatility of the Company's stock price.

The benefits of tax deductions in excess of recognized stock compensation expense are reported as a financing cash flow, rather than as an operating cash flow. In the six months ended June 30, 2011 and 2012, $1.6 million and $0.4 million, respectively, of benefits of such tax deductions related to stock compensation expense were realized and as such were reported as financing cash flows. For the six months ended June 30, 2011 the net change to additional paid in capital related to tax benefits (deficiencies) was $1.4 million which includes the $1.6 million of excess tax benefits offset by $(0.2) million of tax deficiencies. For the six months ended June 30, 2012, the net change to additional

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MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

June 30, 2012

(Unaudited)

NOTE A General (Continued)

paid in capital related to tax benefits (deficiencies) was $0.2 million which includes the $0.4 million of excess tax benefits offset by $(0.2) million of tax deficiencies.

Summarized information related to the Company's stock options for the six months ended June 30, 2012 is as follows:

	Options	Weighted Average Exercise Price
Outstanding, beginning of period	3,841,233	$ 42.65
Granted	1,347,268	47.47
Forfeited	(298,733)	45.27
Exercised	(83,476)	35.98
Outstanding, end of period	4,806,292	$ 43.95
Vested and expected to vest at end of period	4,683,445	$ 43.86
Exercisable, end of period	2,527,059	$ 40.84

All of the Company's options granted during the six months ended June 30, 2012 vest ratably on each anniversary date over the three years subsequent to grant, and all have a ten year life.

Summarized information related to the Company's nonvested restricted stock awards for the six months ended June 30, 2012 is as follows:

	Shares	Weighted Average Grant Date Fair Value
Outstanding, beginning of period	18,748	$ 52.11
Awarded	23,672	42.25
Vested	(18,748)	52.11
Forfeited		
Outstanding, ending of period	23,672	$ 42.25

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MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

June 30, 2012

(Unaudited)

NOTE A General (Continued)

Summarized information related to the Company's nonvested restricted stock units for the six months ended June 30, 2012 is as follows:

	Shares	Weighted Average Grant Date Fair Value
Outstanding, beginning of period	206,338	$ 44.63
Awarded	127,913	47.46
Vested	(99,976)	41.81
Forfeited	(24,302)	47.44
Outstanding, ending of period	209,973	$ 47.36

Grants of restricted stock awards and restricted stock units vest ratably on each anniversary date over the one year and three years, respectively, subsequent to grant.

Long Term Debt and Capital Lease Obligations

On December 9, 2011, the Company entered into a Senior Secured Revolving Credit Facility Credit Agreement with Citibank, N.A., Wells Fargo Bank, N.A., Bank of America, N.A., and U.S. Bank, N.A. that provides for up to $230.0 million of revolving loans with a sublimit of up to $70.0 million for the issuance of letters of credit for the account of the Company (the "2011 Credit Facility"). At such point, the previous credit facility was terminated. The 2011 Credit Facility is guaranteed by substantially all of the subsidiaries of the Company and is secured by substantially all of the assets of the Company and the subsidiary guarantors. The 2011 Credit Facility will mature on December 9, 2014.

Under the 2011 Credit Facility, the annual interest rate on Revolving Loan borrowings is equal to (i) in the case of U.S. dollar denominated loans, the sum of a borrowing margin of 1.00 percent plus the higher of the prime rate, one-half of one percent in excess of the overnight "federal funds" rate, or the Eurodollar rate for one month plus 1.00%, or (ii) in the case of Eurodollar denominated loans, the sum of a borrowing margin of 2.00 percent plus the Eurodollar rate for the selected interest period. The Company has the option to borrow in U.S. dollar denominated loans or Eurodollar denominated loans at its discretion. Letters of Credit issued under the Revolving Loan Commitment bear interest at the rate of 1.875 percent. The commitment commission on the 2011 Credit Facility is 0.375 percent of the unused Revolving Loan Commitment.

There were no material capital lease obligations at December 31, 2011 or June 30, 2012. The Company had $68.1 million and $43.9 million of letters of credit outstanding at December 31, 2011 and June 30, 2012, respectively, and no Revolving Loan borrowings at December 31, 2011 or June 30, 2012.

Reclassifications

Certain prior year amounts have been reclassified to conform with the current year presentation.

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MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

June 30, 2012

(Unaudited)

NOTE B Net Income per Common Share

The following tables reconcile income (numerator) and shares (denominator) used in the computations of net income per common share (in thousands, except per share data):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	**2012**	**2011**	**2012**
Numerator:				
Net income	$ 34,231	$ 26,973	$ 68,529	$ 47,763
Denominator:				
Weighted average number of common shares outstanding basic	31,301	27,317	32,171	27,258
Common stock equivalents stock options	523	328	508	380
Common stock equivalents restricted stock	10	10	13	12
Common stock equivalents restricted stock units	69	61	83	81
Common stock equivalents employee stock purchase plan		1		1
Weighted average number of common shares outstanding diluted	31,903	27,717	32,775	27,732
Net income per common share basic	$ 1.09	$ 0.99	$ 2.13	$ 1.75
Net income per common share diluted	$ 1.07	$ 0.97	$ 2.09	$ 1.72

The weighted average number of common shares outstanding for the three and six months ended June 30, 2011 and 2012 were calculated using outstanding shares of the Company's common stock. Common stock equivalents included in the calculation of diluted weighted average common shares outstanding for the three and six months ended June 30, 2011 and 2012 represent stock options to purchase shares of the Company's common stock, restricted stock awards and restricted stock units, and stock purchased under the Employee Stock Purchase Plan.

The Company had additional potential dilutive securities outstanding representing 1.1 million and 0.8 million options for the three and six months ended June 30, 2011, respectively, and 2.7 million and 2.1 million options for the three and six months ended June 30, 2012, respectively, that were not included in the computation of dilutive securities because they were anti-dilutive for the period. Had these shares not been anti-dilutive, all of these shares would not have been included in the net income per common share calculation as the Company uses the treasury stock method of calculating diluted shares.

NOTE C Business Segment Information

The accounting policies of the Company's segments are the same as those described in Note A "General." The Company evaluates performance of its segments based on profit or loss from operations before stock compensation expense, depreciation and amortization, interest expense, interest income, gain on sale of assets, special charges or benefits, and income taxes ("Segment Profit"). Management uses Segment Profit information for internal reporting and control purposes and considers

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MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

June 30, 2012

(Unaudited)

NOTE C Business Segment Information (Continued)

it important in making decisions regarding the allocation of capital and other resources, risk assessment and employee compensation, among other matters. Effective September 1, 2010, Public Sector has subcontracted with Medicaid Administration to provide pharmacy benefits management services on a risk basis for one of Public Sector's customers. As such, revenue and cost of care related to this intersegment arrangement are eliminated. The Company's segments are defined above.

The following tables summarize, for the periods indicated, operating results by business segment (in thousands):

Three Months Ended June 30, 2011	Commercial	Public Sector	Radiology Benefits Management	Specialty Pharmaceutical Management	Medicaid Administration	Corporate and Elimination	Consolidated
Net revenue	$ 139,686	$ 362,284	$ 90,608	$ 69,366	$ 56,637	$ (20,243)	$ 698,338
Cost of care	(79,122)	(309,934)	(53,828)		(18,805)	20,243	(441,446)
Cost of goods sold				(53,404)			(53,404)
Direct service costs	(39,112)	(16,486)	(15,858)	(6,083)	(25,849)		(103,388)
Other operating expenses						(28,391)	(28,391)
Stock compensation expense(1)	218	214	401	133	41	3,198	4,205
Segment profit (loss)	$ 21,670	$ 36,078	$ 21,323	$ 10,012	$ 12,024	$ (25,193)	$ 75,914

Three Months Ended June 30, 2012	Commercial	Public Sector	Radiology Benefits Management	Specialty Pharmaceutical Management	Medicaid Administration	Corporate and Elimination	Consolidated
Net revenue	$ 178,227	$ 410,136	$ 88,826	$ 101,976	$ 43,026	$ (16,718)	$ 805,473
Cost of care	(110,847)	(355,113)	(57,874)		(14,714)	16,718	(521,830)
Cost of goods sold				(82,855)			(82,855)
Direct service costs	(42,456)	(23,304)	(13,582)	(6,206)	(20,742)		(106,290)
Other operating expenses						(34,043)	(34,043)
Stock compensation expense(1)	270	269	360	152	84	3,230	4,365
Segment profit (loss)	$ 25,194	$ 31,988	$ 17,730	$ 13,067	$ 7,654	$ (30,813)	$ 64,820

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MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

June 30, 2012

(Unaudited)

NOTE C Business Segment Information (Continued)

Six Months Ended June 30, 2011	Commercial	Public Sector	Radiology Benefits Management	Specialty Pharmaceutical Management	Medicaid Administration	Corporate and Elimination	Consolidated
Net revenue	$ 289,721	$ 712,800	$ 179,820	$ 139,596	$ 109,930	$ (40,774)	$ 1,391,093
Cost of care	(154,435)	(614,855)	(108,545)		(38,085)	40,774	(875,146)
Cost of goods sold				(109,923)			(109,923)
Direct service costs	(76,920)	(33,462)	(32,563)	(12,095)	(51,835)		(206,875)
Other operating expenses						(56,471)	(56,471)
Stock compensation expense(1)	469	436	883	259	64	6,872	8,983
Segment profit (loss)	$ 58,835	$ 64,919	$ 39,595	$ 17,837	$ 20,074	$ (49,599)	$ 151,661

Six Months Ended June 30, 2012	Commercial	Public Sector	Radiology Benefits Management	Specialty Pharmaceutical Management	Medicaid Administration	Corporate and Elimination	Consolidated
Net revenue	$ 358,751	$ 799,024	$ 165,683	$ 202,174	$ 90,880	$ (37,826)	$ 1,578,686
Cost of care	(223,019)	(699,425)	(108,284)		(34,221)	37,826	(1,027,123)
Cost of goods sold				(163,893)			(163,893)
Direct service costs	(84,818)	(43,901)	(27,068)	(12,673)	(43,294)		(211,754)
Other operating expenses						(65,168)	(65,168)
Stock compensation expense(1)	537	556	760	324	142	7,148	9,467
Segment profit (loss)	$ 51,451	$ 56,254	$ 31,091	$ 25,932	$ 13,507	$ (58,020)	$ 120,215

(1) Stock compensation expense is included in direct service costs and other operating expenses, however this amount is excluded from the computation of Segment Profit since it is managed on a consolidated basis.

The following table reconciles Segment Profit to income before income taxes (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2012	2011	2012
Segment profit	$ 75,914	$ 64,820	$ 151,661	$ 120,215
Stock compensation expense	(4,205)	(4,365)	(8,983)	(9,467)
Depreciation and amortization	(14,267)	(15,152)	(28,219)	(29,933)

Interest expense		(494)		(576)		(965)		(1,176)
Interest income		858		857		1,673		1,269
Income before income taxes	$	57,806	$	45,584	$	115,167	$	80,908

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MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

June 30, 2012

(Unaudited)

NOTE D Commitments and Contingencies

Legal

The management and administration of the delivery of specialty managed healthcare entails significant risks of liability. From time to time, the Company is subject to various actions and claims arising from the acts or omissions of its employees, network providers or other parties. In the normal course of business, the Company receives reports relating to deaths and other serious incidents involving patients whose care is being managed by the Company. Such incidents occasionally give rise to malpractice, professional negligence and other related actions and claims against the Company or its network providers. Many of these actions and claims received by the Company seek substantial damages and therefore require the Company to incur significant fees and costs related to their defense. The Company is also subject to or party to certain class actions, litigation and claims relating to its operations and business practices. In the opinion of management, the Company has recorded reserves that are adequate to cover litigation, claims or assessments that have been or may be asserted against the Company, and for which the outcome is probable and reasonably estimable. Management believes that the resolution of such litigation and claims will not have a material adverse effect on the Company's financial condition or results of operations; however, there can be no assurance in this regard.

Stock Repurchases

On October 25, 2011 the Company's board of directors approved a stock repurchase plan which authorized the Company to purchase up to $200 million of its outstanding common stock through October 25, 2013.

Stock repurchases under the program may be executed through open market repurchases, privately negotiated transactions, accelerated share repurchases or other means. The board of directors authorized management to execute stock repurchase transactions from time to time and in such amounts and via such methods as management deems appropriate. The stock repurchase program may be limited or terminated at any time without prior notice. Pursuant to this program, the Company made open market purchases of 671,776 shares of the Company's common stock at an average price of $48.72 per share for an aggregate cost of $32.7 million (excluding broker commissions) during the period from November 11, 2011 through December 31, 2011.

The Company made no open market purchases during the six months ended June 30, 2012 or for the period from July 1, 2012 through July 24, 2012.

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

The following discussion and analysis of the financial condition and results of operations of Magellan and its majority-owned subsidiaries and all VIEs for which Magellan is the primary beneficiary should be read together with the Consolidated Financial Statements and the notes to the Consolidated Financial Statements included elsewhere in this Quarterly Report on Form 10-Q and the Company's Annual Report on Form 10-K for the year ended December 31, 2011, which was filed with the SEC on February 28, 2012.

Forward-Looking Statements

This Form 10-Q includes "forward-looking statements" within the meaning of Section 27A of the Securities Act and Section 21E of the Exchange Act. Although the Company believes that its plans, intentions and expectations as reflected in such forward-looking statements are reasonable, it can give no assurance that such plans, intentions or expectations will be achieved. Prospective investors are cautioned that any such forward-looking statements are not guarantees of future performance and involve risks and uncertainties, and that actual results may differ materially from those contemplated by such forward-looking statements. Important factors currently known to management that could cause actual results to differ materially from those in forward-looking statements include:

- the Company's inability to renegotiate or extend expiring customer contracts, or the termination of customer contracts;
- the Company's inability to integrate acquisitions in a timely and effective manner;
- changes in business practices of the industry, including the possibility that certain of the Company's managed care customers could seek to provide managed healthcare services directly to their subscribers, instead of contracting with the Company for such services, particularly as a result of further consolidation in the managed care industry and especially regarding managed healthcare customers that have already done so with a portion of their membership;
- the impact of changes in the contracting model for Medicaid contracts, including certain changes in the contracting model used by states for managed healthcare services contracts relating to Medicaid lives;
- the Company's ability to accurately predict and control healthcare costs, and to properly price the Company's services;
- Fluctuation in quarterly operating results due to seasonal and other factors;
- the Company's dependence on government spending for managed healthcare, including changes in federal, state and local healthcare policies;
- restrictive covenants in the Company's debt instruments;
- present or future state regulations and contractual requirements that the Company provide financial assurance of its ability to meet its obligations;
- the impact of the competitive environment in the managed healthcare services industry which may limit the Company's ability to maintain or obtain contracts, as well as its ability to maintain or increase its rates;
- the impact of healthcare reform legislation;

the Mental and Substance Abuse Benefit Parity Law and Regulations;

government regulation;

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- the possible impact of additional regulatory scrutiny and liability associated with the Company's Specialty Pharmaceutical Management segment;
- the inability to realize the value of goodwill and intangible assets;
- pending or future actions or claims for professional liability;
- claims brought against the Company that either exceed the scope of the Company's liability coverage or result in denial of coverage;
- class action suits and other legal proceedings;
- the impact of governmental investigations;
- the impact of varying economic and market conditions on the Company's investment portfolio; and
- the state of the national economy and adverse changes in economic conditions.

Further discussion of factors currently known to management that could cause actual results to differ materially from those in forward-looking statements is set forth under the heading "Risk Factors" in Item 1A of Magellan's Annual Report on Form 10-K for the year ended December 31, 2011. When used in this Quarterly Report on Form 10-Q, the words "estimate," "anticipate," "expect," "believe," "should," and similar expressions are intended to be forward-looking statements. Magellan undertakes no obligation to update or revise forward-looking statements to reflect changed assumptions, the occurrence of unanticipated events or changes to future operating results over time, except as required by law.

Business Overview

The Company is engaged in the specialty managed healthcare business. Through 2005, the Company predominantly operated in the managed behavioral healthcare business. As a result of certain acquisitions, the Company expanded into radiology benefits management and specialty pharmaceutical management during 2006, and into Medicaid administration during 2009. The Company provides services to health plans, insurance companies, employers, labor unions and various governmental agencies. The Company's business is divided into the following six segments, based on the services it provides and/or the customers that it serves, as described below.

Managed Behavioral Healthcare

Two of the Company's segments are in the managed behavioral healthcare business. This line of business generally reflects the Company's coordination and management of the delivery of behavioral healthcare treatment services that are provided through its contracted network of third-party treatment providers, which includes psychiatrists, psychologists, other behavioral health professionals, psychiatric hospitals, general medical facilities with psychiatric beds, residential treatment centers and other treatment facilities. The treatment services provided through the Company's provider network include outpatient programs (such as counseling or therapy), intermediate care programs (such as intensive outpatient programs and partial hospitalization services), inpatient treatment and crisis intervention services. The Company generally does not directly provide or own any provider of treatment services.

The Company provides its management services primarily through: (i) risk-based products, where the Company assumes all or a substantial portion of the responsibility for the cost of providing treatment services in exchange for a fixed per member per month fee, (ii) ASO products, where the Company provides services such as utilization review, claims administration and/or provider network management, but does not assume responsibility for the cost of the treatment services, and (iii) EAPs where the Company provides short-term outpatient behavioral counseling services.

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The managed behavioral healthcare business is managed based on the services provided and/or the customers served, through the following two segments:

Commercial. The Commercial segment generally reflects managed behavioral healthcare services and EAP services provided under contracts with health plans and insurance companies for some or all of their commercial, Medicaid and Medicare members, as well as with employers, including corporations, governmental agencies, and labor unions. Commercial's contracts encompass risk-based, ASO and EAP arrangements. As of June 30, 2012, Commercial's covered lives were 5.4 million, 13.2 million and 12.1 million for risk-based, ASO and EAP products, respectively. For the six months ended June 30, 2012, Commercial's revenue was $256.7 million, $61.2 million and $40.9 million for risk-based, ASO and EAP products, respectively.

Public Sector. The Public Sector segment generally reflects services provided to recipients under Medicaid and other state sponsored programs under contracts with state and local governmental agencies. Public Sector contracts encompass either risk-based or ASO arrangements. As of June 30, 2012, Public Sector's covered lives were 1.9 million and 1.1 million for risk-based and ASO products, respectively. For the six months ended June 30, 2012, Public Sector's revenue was $787.4 million and $11.6 million for risk-based and ASO products, respectively.

Radiology Benefits Management

The Radiology Benefits Management segment generally reflects the management of the delivery of diagnostic imaging and other therapeutic services to ensure that such services are clinically appropriate and cost effective. The Company's radiology benefits management services currently are provided under contracts with health plans and insurance companies for some or all of their commercial, Medicaid and Medicare members. The Company also contracts with state and local governmental agencies for the provision of such services to Medicaid recipients. The Company offers its radiology benefits management services through risk-based contracts, where the Company assumes all or a substantial portion of the responsibility for the cost of providing diagnostic imaging services, and through ASO contracts, where the Company provides services such as utilization review and claims administration, but does not assume responsibility for the cost of the imaging services. As of June 30, 2012, covered lives for Radiology Benefits Management were 4.3 million and 12.8 million for risk-based and ASO products, respectively. For the six months ended June 30, 2012, revenue for Radiology Benefits Management was $145.0 million and $20.7 million for risk-based and ASO products, respectively.

Drug Benefits Management

Two of the Company's segments are in the drug benefits management business. This line of business generally reflects the Company's clinical management of drugs paid under medical and pharmacy benefit programs. The Company's services include the coordination and management of the specialty drug spending for health plans, employers, and governmental agencies, and the management of pharmacy programs for Medicaid and other state-sponsored programs. The two segments in this business line are:

Specialty Pharmaceutical Management. The Specialty Pharmaceutical Management segment comprises programs that manage specialty drugs used in the treatment of complex conditions such as cancer, multiple sclerosis, hemophilia, infertility, rheumatoid arthritis, chronic forms of hepatitis and other diseases. Specialty pharmaceutical drugs represent high-cost injectible, infused, or oral drugs with sensitive handling or storage needs, many of which may be physician administered. Patients receiving these drugs require greater amounts of clinical support than those taking more traditional agents. Payors require clinical, financial and technological support to maximize the value delivered to their members using these expensive agents. The Company's specialty pharmaceutical management services are provided under contracts with health plans, insurance companies, employers, and governmental

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agencies for some or all of their commercial, Medicare and Medicaid members. The Company's specialty pharmaceutical services include: (i) contracting and formulary optimization programs; (ii) specialty pharmaceutical dispensing operations; and (iii) medical pharmacy management programs. The Company's Specialty Pharmaceutical Management segment had contracts with 40 health plans and several pharmaceutical manufacturers and state Medicaid programs as of June 30, 2012.

Medicaid Administration. The Medicaid Administration segment generally reflects integrated clinical management services provided to the public sector to manage Medicaid pharmacy, mental health, and long-term care programs. The primary focus of the Company's Medicaid Administration unit involves providing pharmacy benefits administration ("PBA") and pharmacy benefits management ("PBM") services under contracts with health plans and public sector healthcare clients for Medicaid and other state sponsored program recipients. The Company's services include pharmacy point-of-sale claims processing systems and administration, drug utilization review, clinical prior authorization, utilization and formulary management services, Preferred Drug List programs, Maximum Allowable Cost programs, and drug rebate program services. Medicaid Administration's contracts encompass Fee-For-Service ("FFS") arrangements. In addition to Medicaid Administration's FFS contracts, effective September 1, 2010, Public Sector has subcontracted with Medicaid Administration to provide pharmacy benefits management services on a risk basis for one of Public Sector's customers.

Corporate

This segment of the Company is comprised primarily of operational support functions such as sales and marketing and information technology, as well as corporate support functions such as executive, finance, human resources and legal.

Significant Customers

Consolidated Company

The Company provides behavioral healthcare management and other related services to approximately 715,000 members in Maricopa County, Arizona, the ("Maricopa Contract").

Under the Maricopa Contract, the Company is responsible for providing covered behavioral health services to persons eligible under Title XIX (Medicaid) and Title XXI (State Children's Health Insurance Program) of the Social Security Act, non-Title XIX and non-Title XXI eligible children and adults with a serious mental illness, and to certain non-Title XIX and non-Title XXI adults with behavioral health or substance abuse disorders. The Maricopa Contract began on September 1, 2007 and extends through September 30, 2013 unless sooner terminated by the parties. The State of Arizona has the right to terminate the Maricopa Contract for cause, as defined, upon ten days' notice with an opportunity to cure, and without cause immediately upon notice from the State. The Maricopa Contract generated net revenues of $383.6 million and $383.2 million for the six months ended June 30, 2011 and 2012, respectively.

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By Segment

In addition to the Maricopa Contract previously discussed, the following customers generated in excess of ten percent of net revenues for the respective segment for the six months ended June 30, 2011 and 2012 (in thousands):

Segment	Term Date	2011	2012
Commercial			
Customer A	December 31, 2013	$ 91,606	$ 96,106
Customer B	June 30, 2014	33,402	32,137*
Customer C	December 31, 2012 to December 14, 2013(1)	54,796	60,923
Customer D	December 31, 2019		67,381
Public Sector			
Customer E	June 30, 2013(2)	81,060	111,259
Radiology Benefits Management			
Customer F	December 31, 2015	67,392	53,405
Customer G	June 30, 2011 to November 30, 2011(1)(3)	30,934	
Customer H	June 30, 2014	26,720	29,049
Customer I	March 31, 2013	16,157*	28,092
Customer J	January 31, 2014	15,801*	18,333
Specialty Pharmaceutical Management			
Customer K	November 30, 2012 to December 31, 2013(1)	42,989	64,651
Customer L	September 1, 2012 to April 29, 2013(1)	27,963	30,643
Customer B	December 31, 2012 to September 27, 2013(1)	9,733*	33,746
Medicaid Administration			
Customer M	December 4, 2011(3)	13,805	
Customer N	September 30, 2013(4)	40,774	37,826
Customer O	March 31, 2015 to June 30, 2017(1)	12,466	12,880
Customer P	June 30, 2013 to September 30, 2014(1)	11,411	9,879

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* Revenue amount did not exceed ten percent of net revenues for the respective segment for the period presented. Amount is shown for comparative purposes only.

(1) The customer has more than one contract. The individual contracts are scheduled to terminate at various points during the time period indicated above.

(2) Contract has options for the customer to extend the term for two additional one-year periods.

(3) The contract has terminated.

(4) This customer represents a subcontract with a Public Sector customer and is eliminated in consolidation.

Concentration of Business

The Company also has a significant concentration of business with various counties in the State of Pennsylvania (the "Pennsylvania Counties") which are part of the Pennsylvania Medicaid program, and with various areas in the State of Florida (the "Florida Areas") which are part of the Florida Medicaid program. Net revenues from the Pennsylvania Counties in the aggregate totaled $178.2 million and

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$182.4 million for the six months ended June 30, 2011 and 2012, respectively. Net revenues from the Florida Areas in the aggregate totaled $67.2 million and $67.7 million for the six months ended June 30, 2011 and 2012, respectively.

The Company's contracts with customers typically have terms of one to three years, and in certain cases contain renewal provisions (at the customer's option) for successive terms of between one and two years (unless terminated earlier). Substantially all of these contracts may be immediately terminated with cause and many of the Company's contracts are terminable without cause by the customer or the Company either upon the giving of requisite notice and the passage of a specified period of time (typically between 60 and 180 days) or upon the occurrence of other specified events. In addition, the Company's contracts with federal, state and local governmental agencies generally are conditioned on legislative appropriations. These contracts generally can be terminated or modified by the customer if such appropriations are not made.

Critical Accounting Policies and Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Significant estimates of the Company include, among other things, accounts receivable realization, valuation allowances for deferred tax assets, valuation of goodwill and intangible assets, medical claims payable, other medical liabilities, stock compensation assumptions, tax contingencies and legal liabilities. Actual results could differ from those estimates. Except as noted below, the Company's critical accounting policies are summarized in the Company's Annual Report on Form 10-K, filed with the SEC on February 28, 2012.

Income Taxes

The Company's effective income tax rates were 40.5 percent and 41.0 percent for the six months ended June 30, 2011 and 2012, respectively. These rates differ from the federal statutory income tax rate primarily due to state income taxes and permanent differences between book and tax income. The Company also accrues interest and penalties related to unrecognized tax benefits in its provision for income taxes. The effective income tax rate for the six months ended June 30, 2012 is higher than the effective rate for the six months ended June 30, 2011 mainly due to an increase in effective state tax rates.

The Company files a consolidated federal income tax return for the Company and its eighty percent or more owned subsidiaries, and the Company and its subsidiaries file income tax returns in various states and local jurisdictions. With few exceptions, the Company is no longer subject to state or local income tax assessments by tax authorities for years ended prior to 2008. Further, it is reasonably possible the statutes of limitation regarding the assessment of federal and certain state and local income taxes for 2008 will expire during 2012.

Results of Operations

The accounting policies of the Company's segments are the same as those described in Note A "General." The Company evaluates performance of its segments based on Segment Profit. Management uses Segment Profit information for internal reporting and control purposes and considers it important in making decisions regarding the allocation of capital and other resources, risk assessment and employee compensation, among other matters. Effective September 1, 2010, Public Sector has subcontracted with Medicaid Administration to provide pharmacy benefits management services on a risk basis for one of Public Sector's customers. As such, revenue and cost of care related to this

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intersegment arrangement are eliminated. The Company's segments are defined above. The following tables summarize, for the periods indicated, operating results by business segment (in thousands):

Three Months Ended June 30, 2011	Commercial	Public Sector	Radiology Benefits Management	Specialty Pharmaceutical Management	Medicaid Administration	Corporate and Elimination	Consolidated
Net revenue	$ 139,686	$ 362,284	$ 90,608	$ 69,366	$ 56,637	$ (20,243)	$ 698,338
Cost of care	(79,122)	(309,934)	(53,828)		(18,805)	20,243	(441,446)
Cost of goods sold				(53,404)			(53,404)
Direct service costs	(39,112)	(16,486)	(15,858)	(6,083)	(25,849)		(103,388)
Other operating expenses						(28,391)	(28,391)
Stock compensation expense(1)	218	214	401	133	41	3,198	4,205
Segment profit (loss)	$ 21,670	$ 36,078	$ 21,323	$ 10,012	$ 12,024	$ (25,193)	$ 75,914

Three Months Ended June 30, 2012	Commercial	Public Sector	Radiology Benefits Management	Specialty Pharmaceutical Management	Medicaid Administration	Corporate and Elimination	Consolidated
Net revenue	$ 178,227	$ 410,136	$ 88,826	$ 101,976	$ 43,026	$ (16,718)	$ 805,473
Cost of care	(110,847)	(355,113)	(57,874)		(14,714)	16,718	(521,830)
Cost of goods sold				(82,855)			(82,855)
Direct service costs	(42,456)	(23,304)	(13,582)	(6,206)	(20,742)		(106,290)
Other operating expenses						(34,043)	(34,043)
Stock compensation expense(1)	270	269	360	152	84	3,230	4,365
Segment profit (loss)	$ 25,194	$ 31,988	$ 17,730	$ 13,067	$ 7,654	$ (30,813)	$ 64,820

Six Months Ended June 30, 2011	Commercial	Public Sector	Radiology Benefits Management	Specialty Pharmaceutical Management	Medicaid Administration	Corporate and Elimination	Consolidated
Net revenue	$ 289,721	$ 712,800	$ 179,820	$ 139,596	$ 109,930	$ (40,774)	$ 1,391,093
Cost of care	(154,435)	(614,855)	(108,545)		(38,085)	40,774	(875,146)
Cost of goods sold				(109,923)			(109,923)
Direct service costs	(76,920)	(33,462)	(32,563)	(12,095)	(51,835)		(206,875)
Other operating expenses						(56,471)	(56,471)
Stock compensation expense(1)	469	436	883	259	64	6,872	8,983
Segment profit (loss)	$ 58,835	$ 64,919	$ 39,595	$ 17,837	$ 20,074	$ (49,599)	$ 151,661

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Six Months Ended June 30, 2012	Commercial	Public Sector	Radiology Benefits Management	Specialty Pharmaceutical Management	Medicaid Administration	Corporate and Elimination	Consolidated
Net revenue	$ 358,751	$ 799,024	$ 165,683	$ 202,174	$ 90,880	$ (37,826)	$ 1,578,686
Cost of care	(223,019)	(699,425)	(108,284)		(34,221)	37,826	(1,027,123)
Cost of goods sold				(163,893)			(163,893)
Direct service costs	(84,818)	(43,901)	(27,068)	(12,673)	(43,294)		(211,754)
Other operating expenses						(65,168)	(65,168)
Stock compensation expense(1)	537	556	760	324	142	7,148	9,467
Segment profit (loss)	$ 51,451	$ 56,254	$ 31,091	$ 25,932	$ 13,507	$ (58,020)	$ 120,215

(1) Stock compensation expense is included in direct service costs and other operating expenses, however this amount is excluded from the computation of Segment Profit since it is managed on a consolidated basis.

The following table reconciles Segment Profit to income before income taxes (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2012	2011	2012
Segment profit	$ 75,914	$ 64,820	$ 151,661	$ 120,215
Stock compensation expense	(4,205)	(4,365)	(8,983)	(9,467)
Depreciation and amortization	(14,267)	(15,152)	(28,219)	(29,933)
Interest expense	(494)	(576)	(965)	(1,176)
Interest income	858	857	1,673	1,269
Income before income taxes	$ 57,806	$ 45,584	$ 115,167	$ 80,908

Quarter ended June 30, 2012 ("Current Year Quarter"), compared to the quarter ended June 30, 2011 ("Prior Year Quarter")

Commercial

Net Revenue

Net revenue related to Commercial increased by 27.6 percent or $38.5 million from the Prior Year Quarter to the Current Year Quarter. The increase in revenue is mainly due to new business of $34.2 million, favorable rate changes of $6.6 million, and higher performance-based revenue in the Current Year Quarter of $2.3 million, which increases were partially offset by program changes of $2.7 million, terminated contracts of $1.0 million, and other net decreases of $0.9 million.

Cost of Care

Cost of care increased by 40.1 percent or $31.7 million from the Prior Year Quarter to the Current Year Quarter. The increase in cost of care is primarily due to new business of $28.2 million, unfavorable medical claims development for the Prior Year Quarter which was recorded after the Prior Year Quarter of $2.1 million, and unfavorable care trends and other net variances of $5.1 million, which increases were partially offset by program changes of $2.7 million and favorable prior period medical claims development recorded in the Current Year Quarter of $1.0 million. Cost of care increased as a percentage of risk revenue (excluding EAP business) from 78.4 percent in the Prior Year Quarter to 80.4 percent in the Current Year Quarter, mainly due to changes in business mix.

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Direct Service Costs

Direct service costs increased by 8.5 percent or $3.3 million from the Prior Year Quarter to the Current Year Quarter, mainly due to costs to support new business. Direct service costs decreased as a percentage of revenue from 28.0 percent in the Prior Year Quarter to 23.8 percent in the Current Year Quarter, mainly due to changes in business mix.

Public Sector

Net Revenue

Net revenue related to Public Sector increased by 13.2 percent or $47.9 million from the Prior Year Quarter to the Current Year Quarter. This increase is primarily due to new business of $55.3 million, unfavorable retroactive contract funding adjustments in the Prior Year Quarter of $6.6 million, increased membership from existing customers of $4.1 million, and other net increases of $3.7 million, which increases were partially offset by unfavorable rate changes of $15.0 million and net incentive revenue recorded in the Prior Year Quarter of $6.8 million.

Cost of Care

Cost of care increased by 14.6 percent or $45.2 million from the Prior Year Quarter to the Current Year Quarter. This increase is primarily due to new business of $43.2 million, care associated with retroactive contract funding changes in the Prior Year Quarter of $7.4 million, increased membership from existing customers of $4.0 million, and unfavorable care trends and other net variances of $3.9 million, which increases were partially offset by care associated with rate changes for contracts with minimum care requirements of $11.1 million and favorable contractual settlements of $2.2 million in the Current Year Quarter. Cost of care increased as a percentage of risk revenue from 85.9 percent in the Prior Year Quarter to 88.3 percent in the Current Year Quarter mainly due to unfavorable rate changes, unfavorable care trends, and changes in business mix.

Direct Service Costs

Direct service costs increased by 41.4 percent or $6.8 million from the Prior Year Quarter to the Current Year Quarter, mainly due to costs to support new business. Direct service costs increased as a percentage of revenue from 4.6 percent for the Prior Year Quarter to 5.7 percent in the Current Year Quarter mainly due to rate decreases and changes in business mix.

Radiology Benefits Management

Net Revenue

Net revenue related to Radiology Benefits Management decreased by 2.0 percent or $1.8 million from the Prior Year Quarter to the Current Year Quarter. This decrease is primarily due to the net impact of decreased membership from terminated contracts and existing customers of $14.5 million, unfavorable rate changes of $5.5 million, and other net unfavorable variances of $0.4 million, which decreases were partially offset by new business of $12.3 million, favorable contractual settlements of $4.4 million in the Current Year Quarter, and the profit share impact of $1.9 million related to favorable prior period medical claims development in the Prior Year Quarter.

Cost of Care

Cost of care increased by 7.5 percent or $4.0 million from the Prior Year Quarter to the Current Year Quarter. This increase is primarily attributed to new business of $10.8 million, and favorable prior period medical claims development recorded in the Prior Year Quarter of $4.1 million, which increases were partially offset by the impact of care associated with decreased membership from terminated

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contracts and existing customers of $8.6 million, favorable medical claims development for the Prior Year Quarter which was recorded after the Prior Year Quarter of $2.2 million, and other net favorable variances of $0.1 million. Cost of care increased as a percentage of risk revenue from 69.8 percent in the Prior Year Quarter to 73.6 percent in the Current Year Quarter mainly due to unfavorable rate changes in excess of care trends and changes in business mix.

Direct Service Costs

Direct service costs decreased by 14.4 percent or $2.3 million from the Prior Year Quarter to the Current Year Quarter. The decrease in direct service costs is mainly attributable to terminated contracts. As a percentage of revenue, direct service costs decreased from 17.5 percent in the Prior Year Quarter to 15.3 percent in the Current Year Quarter, mainly due to changes in business mix.

Specialty Pharmaceutical Management

Net Revenue

Net revenue related to Specialty Pharmaceutical Management increased by 47.0 percent or $32.6 million from the Prior Year Quarter to the Current Year Quarter. This increase is primarily due to net increased specialty pharmacy revenue of $30.8 million, retroactive revenue adjustments recorded in the Current Year Quarter of $2.0 million, increased formulary optimization revenue of $0.7 million, and increased medical pharmacy management revenue of $0.7 million, which increases were partially offset by the recognition of medical pharmacy management revenue in the Prior Year Quarter which was previously deferred of $1.6 million.

Cost of Goods Sold

Cost of goods sold increased by 55.1 percent or $29.5 million from the Prior Year Quarter to the Current Year Quarter. This increase is primarily due to increased specialty pharmacy business. As a percentage of the portion of net revenue that relates to dispensing activity, cost of goods sold decreased from 94.4 percent in the Prior Year Quarter to 93.6 percent in the Current Year Quarter, mainly due to business mix.

Direct Service Costs

Direct service costs increased by 2.0 percent or $0.1 million from the Prior Year Quarter to the Current Year Quarter. As a percentage of revenue, direct service costs decreased from 8.8 percent in the Prior Year Quarter to 6.1 percent in the Current Year Quarter, mainly due to changes in business mix.

Medicaid Administration

Net Revenue

Net revenue related to Medicaid Administration decreased by 24.0 percent or $13.6 million from the Prior Year Quarter to the Current Year Quarter. This decrease is primarily due to terminated contracts of $5.0 million, decreased revenue associated with the subcontract with Public Sector of $3.5 million, decreased pharmacy revenue of $2.1 million, and other net decreases of $3.0 million.

Cost of Care

Cost of care decreased by 21.8 percent or $4.1 million from the Prior Year Quarter to the Current Year Quarter. This decrease is primarily due to favorable care trends. Cost of care decreased as a percentage of risk revenue from 92.9 percent in the Prior Year Quarter to 88.0 percent in the Current Year Quarter, mainly due to favorable care trends.

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Direct Service Costs

Direct service costs decreased by 19.8 percent or $5.1 million. This decrease was primarily due to terminated contracts. As a percentage of revenue, direct service costs increased from 45.6 percent in the Prior Year Quarter to 48.2 percent in the Current Year Quarter, mainly due to changes in business mix.

Corporate and Other

Other Operating Expenses

Other operating expenses related to the Corporate and Other Segment increased by 19.9 percent or $5.7 million from the Prior Year Quarter to the Current Year Quarter. The increase results primarily from an increase in costs of $2.6 million related to our growth initiatives, one-time favorable adjustments recorded in the Prior Year Quarter of $1.1 million, and other net increases of $2.0 million. As a percentage of total net revenue, other operating expenses increased from 4.1 percent for the Prior Year Quarter to 4.2 percent for the Current Year Quarter, primarily due to changes in business mix.

Depreciation and Amortization

Depreciation and amortization expense increased by 6.2 percent or $0.9 million for the Prior Year Quarter to the Current Year Quarter, primarily due to asset additions after the Prior Year Quarter.

Interest Expense

Interest expense increased by $0.1 million from the Prior Year Quarter to the Current Year Quarter, mainly due to higher costs associated with the 2011 Credit Facility.

Interest Income

Interest income was $0.9 million in the Current Year Quarter, which is consistent with the Prior Year Quarter.

Income Taxes

The Company's effective income tax rate was 40.8 percent for both the Prior Year Quarter and Current Year Quarter. This rate differs from the federal statutory income tax rate primarily due to state income taxes and permanent differences between book and tax income.

Six months ended June 30, 2012 ("Current Year Period"), compared to the six months ended June 30, 2011 ("Prior Year Period")

Commercial

Net Revenue

Net revenue related to Commercial increased by 23.8 percent or $69.0 million from the Prior Year Period to the Current Year Period. The increase in revenue is mainly due to new business of $68.8 million, favorable rate changes of $13.3 million, and higher performance-based revenue in the Current Year Period of $8.9 million ($5.9 million relating to the prior year), which increases were partially offset by favorable retroactive membership and rate adjustments recorded in the Prior Year Period of $7.6 million, program changes of $6.1 million, terminated contracts of $2.1 million, net decreased membership from existing customers of $1.3 million, and other net decreases of $4.9 million.

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Cost of Care

Cost of care increased by 44.4 percent or $68.6 million from the Prior Year Period to the Current Year Period. The increase in cost of care is primarily due to new business of $58.0 million, unfavorable medical claims development for the Prior Year Period which was recorded after the Prior Year Period of $2.5 million, and unfavorable care trends and other net variances of $16.9 million, which increases were partially offset by program changes of $6.1 million and favorable prior period medical claims development recorded in the Current Year Period of $2.7 million. Cost of care increased as a percentage of risk revenue (excluding EAP business) from 72.3 in the Prior Year Period to 81.6 percent in the Current Year Period, mainly due to the impact of retroactive rate adjustments in the Prior Year Period, unfavorable care trends in excess of rate changes, and changes in business mix.

Direct Service Costs

Direct service costs increased by 10.3 percent or $7.9 million from the Prior Year Period to the Current Year Period, mainly due to costs to support new business. Direct service costs decreased as a percentage of revenue from 26.5 percent in the Prior Year Period to 23.6 percent in the Current Year Period, mainly due to changes in business mix.

Public Sector

Net Revenue

Net revenue related to Public Sector increased by 12.1 percent or $86.2 million from the Prior Year Period to the Current Year Period. This increase is primarily due to new business of $84.4 million, increased membership from existing customers of $17.6 million, unfavorable retroactive contract funding adjustments in the Prior Year Period of $12.7 million, the revenue impact for favorable prior period medical claims development recorded in the Prior Year Period of $3.2 million, and other net increases of $4.2 million, which increases were partially offset by unfavorable rate changes of $29.1 million, and net incentive revenue recorded in the Prior Year Period of $6.8 million.

Cost of Care

Cost of care increased by 13.8 percent or $84.6 million from the Prior Year Period to the Current Year Period. This increase is primarily due to new business of $68.4 million, increased membership from existing customers of $17.3 million, care associated with retroactive contract funding changes in the Prior Year Period of $13.4 million, favorable prior period medical claims development recorded in the Prior Year Period of $3.3 million, and unfavorable care trends and other net variances of $6.1 million, which increases were partially offset by care associated with rate changes for contracts with minimum care requirements of $21.7 million, and favorable contractual settlements of $2.2 million in the Current Year Period. Cost of care increased as a percentage of risk revenue from 86.6 percent in the Prior Year Period to 88.8 percent in the Current Year Period mainly due to unfavorable rate changes, unfavorable care trends, and changes in business mix.

Direct Service Costs

Direct service costs increased by 31.2 percent or $10.4 million from the Prior Year Period to the Current Year Period, mainly due to costs to support new business. Direct service costs increased as a percentage of revenue from 4.7 percent for the Prior Year Period to 5.5 percent in the Current Year Period mainly due to rate decreases and changes in business mix.

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Radiology Benefits Management

Net Revenue

Net revenue related to Radiology Benefits Management decreased by 7.9 percent or $14.1 million from the Prior Year Period to the Current Year Period. This decrease is primarily due to the net impact of decreased membership from terminated contracts and existing customers of $30.6 million, unfavorable rate changes of $8.5 million, and other net unfavorable variances of $4.4 million, which decreases were partially offset by new business of $21.2 million, favorable contractual settlements of $4.4 million in the Current Year Period, program changes of $2.9 million, and the profit share impact of $0.9 million related to favorable prior period medical claims development in the Prior Year Period.

Cost of Care

Cost of care decreased by 0.2 percent or $0.3 million from the Prior Year Period to the Current Year Period. This decrease is primarily attributed to the impact of care associated with decreased membership from terminated contracts and existing customers of $18.2 million, favorable medical claims development for the Prior Year Period which was recorded after the Prior Year Period of $2.7 million, and other net favorable variances of $2.5 million, which decreases were partially offset by new business of $17.8 million, program changes of $2.9 million, and favorable prior period medical claims development recorded in the Prior Year Period of $2.4 million. Cost of care increased as a percentage of risk revenue from 70.7 percent in the Prior Year Period to 74.7 percent in the Current Year Period mainly due to unfavorable rate changes in excess of care trends and changes in business mix.

Direct Service Costs

Direct service costs decreased by 16.9 percent or $5.5 million from the Prior Year Period to the Current Year Period. The decrease in direct service costs is mainly attributable to terminated contracts. As a percentage of revenue, direct service costs decreased from 18.1 percent in the Prior Year Period to 16.3 percent in the Current Year Period, mainly due to changes in business mix.

Specialty Pharmaceutical Management

Net Revenue

Net revenue related to Specialty Pharmaceutical Management increased by 44.8 percent or $62.6 million from the Prior Year Period to the Current Year Period. This increase is primarily due to net increased specialty pharmacy revenue of $58.0 million, increased formulary optimization revenue of $3.1 million, increased medical pharmacy management revenue of $2.3 million, retroactive revenue adjustments recorded in the Current Year Period of $1.0 million, and other net increases of $0.8 million, which increases were partially offset by the recognition of medical pharmacy management revenue in the Prior Year Period which was previously deferred of $2.6 million.

Cost of Goods Sold

Cost of goods sold increased by 49.1 percent or $54.0 million from the Prior Year Period to the Current Year Period. This increase is primarily due to increased specialty pharmacy business. As a percentage of the portion of net revenue that relates to dispensing activity, cost of goods sold decreased from 94.0 percent in the Prior Year Period to 93.3 percent in the Current Year Period, mainly due to business mix.

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Direct Service Costs

Direct service costs increased by 4.8 percent or $0.6 million from the Prior Year Period to the Current Year Period. As a percentage of revenue, direct service costs decreased from 8.7 percent in the Prior Year Period to 6.3 percent in the Current Year Period, mainly due to changes in business mix.

Medicaid Administration

Net Revenue

Net revenue related to Medicaid Administration decreased by 17.3 percent or $19.1 million from the Prior Year Period to the Current Year Period. This decrease is primarily due to terminated contracts of $12.7 million, decreased pharmacy revenue of $2.2 million, decreased revenue associated with the subcontract with Public Sector of $2.9 million, and other net decreases of $1.3 million.

Cost of Care

Cost of care decreased by 10.1 percent or $3.9 million from the Prior Year Period to the Current Year Period. This decrease is primarily due to favorable care trends. Cost of care decreased as a percentage of risk revenue from 93.4 percent in the Prior Year Period to 90.5 percent in the Current Year Period, mainly due to favorable care trends.

Direct Service Costs

Direct service costs decreased by 16.5 percent or $8.5 million. This decrease was primarily due to terminated contracts. As a percentage of revenue, direct service costs increased from 47.2 percent in the Prior Year Period to 47.6 percent in the Current Year Period, mainly due to changes in business mix.

Corporate and Other

Other Operating Expenses

Other operating expenses related to the Corporate and Other Segment increased by 15.4 percent or $8.7 million from the Prior Year Period to the Current Year Period. The increase results primarily from an increase in costs of $4.9 million related to our growth initiatives, net one-time favorable adjustments recorded in the Prior Year Period of $1.5 million, and other net increases of $2.3 million. As a percentage of total net revenue, other operating expenses were 4.1 percent for both the Prior Year Period and the Current Year Period.

Depreciation and Amortization

Depreciation and amortization expense increased by 6.1 percent or $1.7 million from the Prior Year Period to the Current Year Period, primarily due to asset additions after the Prior Year Period.

Interest Expense

Interest expense increased by $0.2 million from the Prior Year Period to the Current Year Period, mainly due to higher costs associated with the 2011 Credit Facility.

Interest Income

Interest income decreased by $0.4 million from the Prior Year Period to the Current Year Period, mainly due to lower yields.

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Income Taxes

The Company's effective income tax rates were 40.5 percent and 41.0 percent for the Prior Year Period and Current Year Period, respectively. These rates differ from the federal statutory income tax rate primarily due to state income taxes and permanent differences between book and tax income. The effective income tax rate for the Current Year Period is higher than the effective rate for the Prior Year Period mainly due to an increase in effective state tax rates.

Outlook Results of Operations

The Company's Segment Profit and net income are subject to significant fluctuations from period to period. These fluctuations may result from a variety of factors such as those set forth under Item 2 "Forward-Looking Statements" as well as a variety of other factors including: (i) changes in utilization levels by enrolled members of the Company's risk-based contracts, including seasonal utilization patterns; (ii) contractual adjustments and settlements; (iii) retrospective membership adjustments; (iv) timing of implementation of new contracts, enrollment changes and contract terminations; (v) pricing adjustments upon contract renewals (and price competition in general); and (vi) changes in estimates regarding medical costs and IBNR.

A portion of the Company's business is subject to rising care costs due to an increase in the number and frequency of covered members seeking behavioral healthcare or radiology services, and higher costs per inpatient day or outpatient visit for behavioral services, and higher costs per scan for radiology services. Many of these factors are beyond the Company's control. Future results of operations will be heavily dependent on management's ability to obtain customer rate increases that are consistent with care cost increases and/or to reduce operating expenses.

In relation to the managed behavioral healthcare business, the Company is a market leader in a mature market with many viable competitors. The Company is continuing its attempts to grow its business in the managed behavioral healthcare industry through aggressive marketing and development of new products; however, due to the maturity of the market, the Company believes that the ability to grow its current business lines may be limited. In addition, as previously discussed, substantially all of the Company's Commercial segment revenues are derived from Blue Cross Blue Shield health plans and other managed care companies, health insurers and health plans. Certain of the managed care customers of the Company have decided not to renew all or part of their contracts with the Company, and to instead manage the behavioral healthcare services directly for their subscribers.

Care Trends. The Company expects that same-store normalized cost of care trend for the 12-month forward outlook to be approximately 7 to 9 percent, 1 to 3 percent and 4 to 6 percent for Commercial, Public Sector and Radiology Benefits Management, respectively.

Interest Rate Risk. Changes in interest rates affect interest income earned on the Company's cash equivalents and investments, as well as interest expense on variable interest rate borrowings under the Company's 2011 Credit Facility. Based on the amount of cash equivalents and investments and the borrowing levels under the 2011 Credit Facility as of June 30, 2012, a hypothetical 10 percent increase or decrease in the interest rate associated with these instruments, with all other variables held constant, would not materially affect the Company's future earnings and cash outflows.

Historical Liquidity and Capital Resources

Operating Activities. The Company reported net cash used in operating activities of $1.9 million for the Prior Year Period and net cash provided by operating activities of $75.0 million for the Current Year Period. The $76.9 million increase in operating cash flows from the Prior Year Period to the Current Year Period is primarily attributable to the net shift of restricted funds between cash and investments, which results in an operating cash flow change that is directly offset by an investing cash

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flow change, as well as the net favorable impact of working capital changes between periods. Partially offsetting these items is the reduction in Segment Profit between periods.

During the Prior Year Period and Current Year Period, restricted investments of $84.1 million and $19.5 million, respectively, were shifted to restricted cash that reduced operating cash flows for both periods, resulting in a net increase in operating cash flows between periods of $64.6 million. The net favorable impact of working capital changes between periods totaled $43.7 million, with $26.3 million of this change related to pharmaceutical inventory levels and timing of the settlement of the associated inventory payables. Segment Profit for the Current Year Period decreased $31.4 million from the Prior Year Period.

During the Current Year Period, the Company's restricted cash increased $22.8 million. The change in restricted cash is attributable to an increase in restricted cash of $3.5 million associated with the Company's regulated entities and the net shift of restricted investments to restricted cash of $19.5 million, partially offset by other net decreases of $0.2 million. The net change in restricted cash for the Company's regulated entities is attributable to an increase in restricted cash of $2.4 million that is offset by changes in other assets and liabilities, primarily accounts receivable, accrued liabilities, medical claims payable and other medical liabilities, thus having no impact on operating cash flows, and a net increase of $1.1 million in restricted cash requirements that resulted in an operating cash flow use.

Investing Activities. The Company utilized $26.7 million and $36.9 million during the Prior Year Period and Current Year Period, respectively, for capital expenditures. The additions related to hard assets (equipment, furniture, leaseholds) and capitalized software for the Prior Year Period were $11.1 million and $15.6 million, respectively, as compared to additions for the Current Year Period related to hard assets and capitalized software of $20.2 million and $16.7 million, respectively. In addition, during the Prior Year Period the Company used net cash of $64.8 million for the net purchase of "available for sale" securities, with the Company receiving net cash of $7.7 million from the net maturity of "available for sale" securities.

During the Prior Year Period, the Company purchased certain provider network contracts from a third party for $1.2 million, which resulted in the establishment of an intangible asset. In addition, during the Prior Year Period, the Company received the final working capital settlement of $0.9 million from Coventry in regards to the Company's acquisition of First Health, Inc.

Financing Activities. During the Prior Year Period, the Company paid $211.5 million for the repurchase of treasury stock under the Company's share repurchase program. In addition, the Company received $20.0 million under a share purchase agreement pursuant to which Blue Shield of California purchased shares of the Company's common stock, received $28.8 million from the exercise of stock options and warrants and had other net favorable items of $0.4 million.

During the Current Year Period, the Company received $3.0 million from the exercise of stock options and had other net unfavorable items of $0.7 million.

Outlook Liquidity and Capital Resources

Liquidity. During the remainder of 2012, the Company expects to fund its estimated capital expenditures of $27 million to $37 million with cash from operations. The Company does not anticipate that it will need to draw on amounts available under the 2011 Credit Facility for cash flow needs related to its operations, capital needs or debt service in 2012. The Company also currently expects to have adequate liquidity to satisfy its existing financial commitments over the periods in which they will become due. The Company plans to maintain its current investment strategy of investing in a diversified, high quality, liquid portfolio of investments and continues to closely monitor the situation in the financial markets. The Company estimates that it has no risk of any material permanent loss on its

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investment portfolio; however, there can be no assurance that the Company will not experience any such losses in the future.

Stock Repurchases

On October 25, 2011 the Company's board of directors approved a stock repurchase plan which authorized the Company to purchase up to $200 million of its outstanding common stock through October 25, 2013.

Stock repurchases under the program may be executed through open market repurchases, privately negotiated transactions, accelerated share repurchases or other means. The board of directors authorized management to execute stock repurchase transactions from time to time and in such amounts and via such methods as management deems appropriate. The stock repurchase program may be limited or terminated at any time without prior notice. Pursuant to this program, the Company made open market purchases of 671,776 shares of the Company's common stock at an average price of $48.72 per share for an aggregate cost of $32.7 million (excluding broker commissions) during the period from November 11, 2011 through December 31, 2011.

The Company made no open market purchases during the six months ended June 30, 2012 or for the period from July 1, 2012 through July 24, 2012.

Off-Balance Sheet Arrangements. As of June 30, 2012, the Company has no material off-balance sheet arrangements.

2011 Credit Facility. On December 9, 2011, the Company entered into the 2011 Credit Facility that provides for up to $230.0 million of revolving loans with a sublimit of up to $70.0 million for the issuance of letters of credit for the account of the Company. The 2011 Credit Facility is guaranteed by substantially all of the subsidiaries of the Company and is secured by substantially all of the assets of the Company and the subsidiary guarantors. The 2011 Credit Facility will mature on December 9, 2014.

Under the 2011 Credit Facility, the annual interest rate on Revolving Loan borrowings is equal to (i) in the case of U.S. dollar denominated loans, the sum of a borrowing margin of 1.00 percent plus the higher of the prime rate, one-half of one percent in excess of the overnight "federal funds" rate, or the Eurodollar rate for one month plus 1.00%, or (ii) in the case of Eurodollar denominated loans, the sum of a borrowing margin of 2.00 percent plus the Eurodollar rate for the selected interest period. The Company has the option to borrow in U.S. dollar denominated loans or Eurodollar denominated loans at its discretion. Letters of Credit issued under the Revolving Loan Commitment bear interest at the rate of 2.125 percent. The commitment commission on the 2011 Credit Facility is 0.375 percent of the unused Revolving Loan Commitment.

Restrictive Covenants in Debt Agreements. The 2011 Credit Facility contains covenants that limit management's discretion in operating the Company's business by restricting or limiting the Company's ability, among other things, to:

- incur or guarantee additional indebtedness or issue preferred or redeemable stock;
- pay dividends and make other distributions;
- repurchase equity interests;
- make certain advances, investments and loans;
- enter into sale and leaseback transactions;
- create liens;
- sell and otherwise dispose of assets;

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- acquire or merge or consolidate with another company; and
- enter into some types of transactions with affiliates.

These restrictions could adversely affect the Company's ability to finance future operations or capital needs or engage in other business activities that may be in the Company's interest.

The 2011 Credit Facility also requires the Company to comply with specified financial ratios and tests. Failure to do so, unless waived by the lenders under the 2011 Credit Facility pursuant to its terms, would result in an event of default under the 2011 Credit Facility. As of June 30, 2012, the Company was in compliance with all covenants, including financial covenants, under the 2011 Credit Facility.

Although the 2011 Credit Facility expires on December 9, 2014, the Company believes it will be able to obtain a new facility or, if not, to use cash on hand to fund letters of credit and other liquidity needs.

Net Operating Loss Carryforwards. The Company has federal net operating loss carryforwards ("NOLs") as of December 31, 2011 of approximately $4.8 million available to reduce future federal taxable income. These NOLs, if not used, expire in 2017 through 2019 and are subject to examination and adjustment by the IRS. In addition, the Company's utilization of such NOLs is subject to limitation under Section 382, which affects the timing of the use of these NOLs. At this time, the Company does not believe these limitations will limit its ability to use any federal NOLs before they expire.

As of December 31, 2011, the Company's valuation allowances against deferred tax assets were $3.4 million, mostly relating to uncertainties regarding the eventual realization of certain state NOLs. Determination of the amount of deferred tax assets considered realizable requires significant judgment and estimation regarding the forecasts of future taxable income which are consistent with the plans and estimates the Company uses to manage the underlying businesses. Changes in these estimates in the future could materially affect the Company's financial condition and results of operations.

Recent Accounting Pronouncements

In May 2011, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") No. 2011-04, "Fair Value Measurement (Topic 820): Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRSs", ("ASU 2011-04"). ASU 2011-04 amends ASC Topic 820, "Fair Value Measurements and Disclosures", to provide guidance on how fair value measurement should be applied where existing GAAP already requires or permits fair value measurements. In addition, ASU 2011-04 requires expanded disclosures regarding fair value measurements. ASU 2011-04 became effective for the Company on January 1, 2012. The adoption of ASU 2011-04 did not have a material impact on the Company's results of operations or financial position.

In June 2011, the FASB issued ASU No. 2011-05, "Comprehensive Income (Topic 220): Presentation of Comprehensive Income" ("ASU 2011-05"). ASU 2011-05 requires an entity to present the total of comprehensive income, the components of net income, and the components of other comprehensive income either in a single continuous statement of comprehensive income or in two separate but consecutive statements and eliminates the option to present the components of other comprehensive income as part of the statement of equity. ASU 2011-05 became effective for the Company on January 1, 2012. While the adoption of this guidance impacts the Company's disclosures for annual and interim filings for the year ending December 31, 2012, it does not impact the Company's results of operations or financial position.

In September 2011, the FASB issued ASU 2011-08, "Testing Goodwill for Impairment" ("ASU 2011-8"), which provides authoritative guidance to simplify how entities, both public and nonpublic, test

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goodwill for impairment. This accounting update permits an entity to first assess qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount as a basis for determining whether it is necessary to perform the two-step goodwill impairment test. This guidance was effective for the Company beginning on January 1, 2012. This guidance did not impact the Company's financial position, results of operations or cash flows.

In December 2011, the FASB issued ASU 2011-12 "Deferral of the Effective Date for Amendments to the Presentation of Reclassifications of Items Out of Accumulated Other Comprehensive Income in ASU 2011-05" ("ASU 2011-12"), which defers the requirement that companies present reclassification adjustments for each component of accumulated other comprehensive income in both net income and other comprehensive income on the face of the financial statements. The effective dates for ASU 2011-12 are consistent with the effective dates for ASU 2011-05 and, similar to our expectations for the adoption of ASU 2011-05, while the adoption of this guidance impacts the Company's disclosures for annual and interim filings for the year ending December 31, 2012, it does not impact the Company's results of operations or financial position.

Item 3. Quantitative and Qualitative Disclosures about Market Risk.

Changes in interest rates affect interest income earned on the Company's cash equivalents and restricted cash and investments, as well as interest expense on variable interest rate borrowings under the 2011 Credit Facility. Based on the Company's investment balances, and the borrowing levels under the 2011 Credit Facility as of June 30, 2012, a hypothetical 10 percent increase or decrease in the interest rate associated with these instruments, with all other variables held constant, would not materially affect the Company's future earnings and cash outflows.

Item 4. Controls and Procedures.

a) The Company's management evaluated, with the participation of the Company's principal executive and principal financial officers, the effectiveness of the Company's disclosure controls and procedures (as defined in Rules 13a-15(e) under the Exchange Act), as of June 30, 2012. Based on their evaluation, the Company's principal executive and principal financial officers concluded that the Company's disclosure controls and procedures were effective as of June 30, 2012.

b) Under the supervision and with the participation of management, including the Company's principal executive and principal financial officers, the Company has determined that there has been no change in the Company's internal control over financial reporting (as defined in Rule 13a-15(f) under the Exchange Act) that occurred during the Company's quarter ended June 30, 2012 that has materially affected, or is reasonably likely to materially affect, the Company's internal control over financial reporting.

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PART II OTHER INFORMATION

Item 1. Legal Proceedings.

The management and administration of the delivery of specialty managed healthcare entails significant risks of liability. From time to time, the Company is subject to various actions and claims arising from the acts or omissions of its employees, network providers or other parties. In the normal course of business, the Company receives reports relating to deaths and other serious incidents involving patients whose care is being managed by the Company. Such incidents occasionally give rise to malpractice, professional negligence and other related actions and claims against the Company or its network providers. Many of these actions and claims received by the Company seek substantial damages and therefore require the Company to incur significant fees and costs related to their defense. The Company is also subject to or party to certain class actions, litigation and claims relating to its operations or business practices. In the opinion of management, the Company has recorded reserves that are adequate to cover litigation, claims or assessments that have been or may be asserted against the Company, and for which the outcome is probable and reasonably estimable. Management believes that the resolution of such litigation and claims will not have a material adverse effect on the Company's financial condition or results of operations; however, there can be no assurance in this regard.

Item 1A. Risk Factors.

None.

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

The Company's board of directors has previously authorized a series of stock repurchase plans. Stock repurchases for each such plan could be executed through open market repurchases, privately negotiated transactions, accelerated share repurchases or other means. The board of directors authorized management to execute stock repurchase transactions from time to time and in such amounts and via such methods as management deemed appropriate. Each stock repurchase program could be limited or terminated at any time without prior notice.

On July 27, 2010 the Company's board of directors approved a stock repurchase plan which authorized the Company to purchase up to $350 million of its outstanding common stock through July 28, 2012. On February 18, 2011, the Company's board of directors increased the stock repurchase program by an additional $100 million, to a total of $450 million. Pursuant to this program, the Company made open market purchases of 1,684,510 shares of the Company's common stock at an average price of $48.36 per share for an aggregate cost of $81.5 million (excluding broker commissions) during the period from November 3, 2010 through December 31, 2010. Pursuant to this program, the Company made open market purchases of 7,534,766 shares of the Company's common stock at an average price of $48.91 per share for an aggregate cost of $368.5 million (excluding broker commissions) during the period January 1, 2011 through November 10, 2011, which was the date the repurchase program was completed.

On October 25, 2011 the Company's board of directors approved a stock repurchase plan which authorized the Company to purchase up to $200 million of its outstanding common stock through October 25, 2013. Pursuant to this program, the Company made open market purchases of 671,776 shares of the Company's common stock at an average price of $48.72 per share for an aggregate cost of $32.7 million (excluding broker commissions) during the period from November 11, 2011 through December 31, 2011.

The Company made no open market purchases during the six months ended June 30, 2012 or for the period from July 1, 2012 through July 24, 2012.

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Item 3. Defaults Upon Senior Securities.

None.

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

None.

Item 5. Other Information.

None.

Item 6. Exhibits.

Exhibit No.	Description
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes Oxley Act of 2002.
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1	Certification of Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 (furnished).
32.2	Certification of Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 (furnished).
101	The following materials from the Company's Annual Report on Form 10-Q for the quarter ended June 30, 2012 formatted in Extensible Business Reporting Language (XBRL): (i) the Consolidated Statements of Comprehensive Income, (ii) the Consolidated Balance Sheets, (iii) the Consolidated Statements of Cash Flows and (iv) related notes.

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SIGNATURES

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

Date: July 27, 2012

MAGELLAN HEALTH SERVICES, INC.
(Registrant)

By: /s/ JONATHAN N. RUBIN

Jonathan N. Rubin
Executive Vice President and Chief Financial Officer (Principal Financial Officer and Duly Authorized Officer)