MAGELLAN HEALTH SERVICES INC
Form 10-K
February 29, 2008

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

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

For the fiscal year ended December 31, 2007

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)	(I.R.S. Employer Identification No.)
55 Nod Road, Avon, Connecticut	**06001**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: **(860) 507-1900**

Securities registered pursuant to Section 12(b) of the Act: **None.**

Securities registered pursuant to Section 12(g) of the Act: **Ordinary Common Stock par value ($0.01 per share).**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ý No o

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. Yes o No ý

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 if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. o

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, 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 aggregate market value of the common stock held by non-affiliates of the registrant as of June 30, 2007 (the last business day of the registrant's most recently completed second fiscal quarter) was approximately $1.8 billion.

The number of shares of reorganized Magellan Health Services, Inc.'s Ordinary Common Stock outstanding as of February 15, 2008 was 40,280,161.

APPLICABLE ONLY TO REGISTRANTS INVOLVED IN BANKRUPTCY PROCEEDINGS DURING THE PRECEDING FIVE YEARS:

Indicate by check mark whether the registrant has filed all documents and reports required to be filed by Section 12, 13, or 15(d) of the Securities Exchange Act of 1934 subsequent to the distribution of securities under a plan confirmed by a court. Yes ý No o

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the definitive proxy statement for the 2008 Annual Meeting of Shareholders are incorporated by reference.

MAGELLAN HEALTH SERVICES, INC.

REPORT ON FORM 10-K

For the Fiscal Year Ended December 31, 2007

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PART I

Forward-Looking and Cautionary Statements

This Form 10-K includes "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Although the Company (as defined below) believes that its plans, intentions and expectations 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 are set forth under the heading "Risk Factors" in Item 1A and elsewhere in this Form 10-K. When used in this Form 10-K, the words "estimate," "anticipate," "expect," "believe," "should" and similar expressions are intended to be forward-looking statements.

Item 1. Business

Magellan Health Services, Inc. ("Magellan") was incorporated in 1969 under the laws of the State of Delaware. Magellan's executive offices are located at 55 Nod Road, Avon, Connecticut 06001, and its telephone number at that location is (860) 507-1900. Reference in this report to the "Company" includes Magellan, its majority owned subsidiaries, and all variable interest entities ("VIEs") for which Magellan is the primary beneficiary.

Business Overview

The Company is engaged in the specialty managed healthcare business, and its principal offices and operations are in the United States. Through 2005, the Company predominantly operated in the managed behavioral healthcare business. During 2006, the Company expanded into radiology benefits management and specialty pharmaceutical management as a result of its January 31, 2006 acquisition of National Imaging Associates, Inc. ("NIA") and its July 31, 2006 acquisition of ICORE Healthcare LLC ("ICORE"), respectively. The Company provides services to health plans, insurance companies, corporations, 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. The Company's managed behavioral healthcare business is composed of three of the Company's segments, each as described further below. 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 except as relates to the Company's contract to provide managed behavioral healthcare services to Medicaid recipients and other beneficiaries of the Maricopa County Regional Behavioral Health Authority (the "Maricopa Contract"), which is discussed further in Note 10 "Commitments and Contingencies-Maricopa Contract" to the consolidated financial statements set forth elsewhere herein. Under the Maricopa Contract, the Company was required to assume the operations of twenty-four behavioral health direct care facilities for a transitional period and to divest itself of these facilities over the following two years pursuant to a schedule as set forth in the Maricopa Contract.

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 counseling.

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

Health Plan. The Managed Behavioral Healthcare Health Plan segment ("Health Plan") generally reflects managed behavioral healthcare services provided under contracts with managed care companies, health insurers and other health plans for some or all of their commercial, Medicaid and Medicare members. Health Plan's contracts encompass either risk-based or ASO arrangements or both. As of December 31, 2007, Health Plan's covered lives were 5.6 million, 0.2 million and 20.7 million for risk-based, EAP and ASO products, respectively. For the year ended December 31, 2007, Health Plan's revenue was $530.6 million, $1.3 million and $126.5 million for risk-based, EAP and ASO products, respectively.

Employer. The Managed Behavioral Healthcare Employer segment ("Employer") generally reflects the provision of EAP services and managed behavioral healthcare services under contracts with employers, including corporations and governmental agencies, and labor unions. Employer contracts can be for either EAP or managed behavioral healthcare services, or both. Employer contracts containing provision of managed behavioral healthcare services can be risk-based or ASO, but currently are primarily ASO. As of December 31, 2007, Employer's covered lives were 0.1 million, 13.6 million and 0.5 million for risk-based, EAP and ASO products, respectively. For the year ended December 31, 2007, Employer's revenue was $6.4 million, $102.7 million and $17.0 million for risk-based, EAP and ASO products, respectively.

Public Sector. The Managed Behavioral Healthcare Public Sector segment ("Public Sector") generally reflects managed behavioral healthcare services provided to Medicaid recipients under contracts with state and local governmental agencies. Public Sector contracts encompass either risk-based or ASO arrangements. As of December 31, 2007, Public Sector's covered lives were 2.1 million and 0.2 million for risk-based and ASO products, respectively. For the year ended December 31, 2007, Public Sector's revenue was $1.0 billion and $4.4 million for risk-based and ASO products, respectively.

Radiology Benefits Management. The Company's Radiology Benefits Management segment generally reflects the management of the delivery of diagnostic imaging 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 managed care companies, health insurers and other health plans for some or all of their commercial, Medicaid and Medicare members. The Company has bid and may bid in the future on contracts with state and local governmental agencies for the provision of such services to Medicaid recipients. The Company won one Medicaid contract last year; however, its implementation has been postponed by the agency. The Company offers its radiology benefits management services 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 and through risk-based contracts, where the Company assumes all or a substantial portion of the responsibility for the cost of providing diagnostic imaging services. The Company's first two risk-based radiology benefits management contracts became effective June 1, 2007 and July 1, 2007, respectively. As of December 31, 2007, covered lives for Radiology Benefits Management were 2.2 million and 19.1 million for risk-based and ASO products, respectively. For the year ended

December 31, 2007, revenue for Radiology Benefits Management was $118.2 million and $52.0 million for risk-based and ASO products, respectively.

Specialty Pharmaceutical Management. The Company's Specialty Pharmaceutical Management segment generally reflects the management of specialty drugs used in the treatment of cancer, multiple sclerosis, hemophilia, infertility, rheumatoid arthritis, chronic forms of hepatitis and other diseases. Specialty pharmaceutical drugs represent high-cost injectible, infused, oral, or inhaled drugs which traditional retail pharmacies typically do not supply due to their high cost, sensitive handling, and storage needs. The Company's specialty pharmaceutical management services are provided under contracts with managed care companies, health insurers and other health plans for some or all of their commercial, Medicare and Medicaid members. The Company's specialty pharmaceutical services include (i) distributing specialty pharmaceutical drugs on behalf of health plans, (ii) administering on behalf of health plans rebate agreements between health plans and pharmaceutical manufacturers, and (iii) providing consulting services to health plans and pharmaceutical manufacturers. The Company's Specialty Pharmaceutical Management segment had contracts with 30 health plans as of December 31, 2007.

Corporate and Other. 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.

Acquisition of National Imaging Associates

On January 31, 2006, the Company acquired all of the outstanding stock of NIA, a privately held radiology benefits management ("RBM") firm, for approximately $121 million in cash, after giving effect to cash acquired in the transaction, and NIA became a wholly-owned subsidiary. The Company reports the results of operations of NIA in the Radiology Benefits Management segment. For further discussion, see Note 3 "Acquisitions and Joint Ventures" to the consolidated financial statements set forth elsewhere herein.

Acquisition of ICORE Healthcare, LLC

On July 31, 2006, the Company acquired all of the outstanding units of membership interest of ICORE, a specialty pharmaceutical management company, and ICORE became a wholly-owned subsidiary. The Company reports the results of operations of ICORE in the Specialty Pharmaceutical Management segment. For further discussion, see Note 3 "Acquisitions and Joint Ventures" to the consolidated financial statements set forth elsewhere herein.

The Company paid or agreed to pay to the previous unitholders of ICORE, all of whom are members of ICORE's management team, (i) $161 million of cash at closing; (ii) $24 million of cash that was used by the unitholders of ICORE to purchase Magellan restricted stock with such restricted stock vesting over three years, provided the unitholders do not earlier terminate their employment with Magellan; (iii) $25 million plus accrued interest (the "Deferred Payment") on the third anniversary of the closing, subject to any indemnity claims Magellan may have under the purchase agreement; (iv) the amount of positive working capital that existed at ICORE on the closing date (the "Working Capital Payments"), which was $18.2 million of which $17.8 million was paid during 2007 with the remainder paid in January 2008; and (v) a potential earn-out of up to $75 million (the "Earn-Out"), provided the unitholders do not earlier terminate their employment with the Company prior to the payment of the Earn-Out. The $161 million of cash paid at closing, the $25 million Deferred Payment and $18.2 million of Working Capital Payments were recorded as purchase price. The $24 million of restricted stock is being recognized as stock compensation expense over the three year vesting period. The $24 million in restricted stock paid at the closing was issued in a transaction pursuant to which the unitholders of ICORE at closing applied $24 million of the purchase price as cash consideration for their purchase of restricted shares of the Company's common stock. The unitholders subscribed to an

aggregate of 543,879 restricted shares of the Company's common stock on a basis proportional to each unitholder's economic interest in ICORE at a purchase price of $44.13 per share, which was the average of the closing prices of the Company's common stock on NASDAQ for the twenty trading days immediately preceding the closing. The Deferred Payment and the remaining estimated Working Capital Payments are included in Deferred Credits and Other Long-Term Liabilities and in Accrued Liabilities, respectively, on the Company's accompanying consolidated balance sheets as of December 31, 2006 and 2007. The Earn-Out has two parts: (i) up to $25 million based on earnings for the 18 month period ended December 31, 2007 and (ii) up to $50 million based on earnings in 2008. The Earn-Out, if earned, is payable 33 percent in cash and 67 percent in Magellan restricted stock that vests over two years after issuance. Any Earn-Out will be recognized as compensation expense over the applicable period that it is earned, because in order for potential recipients to receive any Earn-Out consideration, they must be employed by the Company at the time such consideration is distributed. The unitholders did not earn any of the potential Earn-Out of $25 million for the 18 month period ended December 31, 2007, nor has any amount of Earn-Out pertaining to 2008 been accrued as of December 31, 2007.

Industry

According to the Centers for Medicare and Medicaid Services ("CMS"), U.S. healthcare spending was projected to increase 6.6 percent to over $2.2 trillion in 2007, representing more than 16 percent of the gross domestic product. Healthcare is a rapidly evolving field where clinical and technological advancements can create business opportunities for firms with specialized expertise in certain niches of care management. The Company has transformed itself into a specialty managed healthcare company by entering areas of healthcare cost management that represent a meaningful portion of the healthcare dollar and that are growing at a disproportionately higher rate than other areas of healthcare. The Company defines areas of healthcare that can be carved out for specialty healthcare management to be areas where:

The management and cost of care are separable from other areas of healthcare management;

The Company believes that it can provide value to its customers in managing the care beyond what such customers can achieve on their own;

The value that the Company provides to its customers is measurable.

The Company's first specialty healthcare product was the management of behavioral healthcare. In 2006 the Company added both radiology benefits management and specialty pharmaceutical management services to its product offering through acquisitions of companies in these businesses.

Business Strategy

The Company is engaged in the specialty managed healthcare business. It currently provides managed behavioral healthcare services, radiology benefit management services, and specialty pharmaceutical management services. The Company's strategy is to expand its participation in the healthcare management services market through the expansion of its existing businesses and diversification into new specialties and services. The Company believes that its clients would prefer to consolidate outsourced vendors and that as a vendor offering multiple outsourced products, it will have a competitive advantage in the market. The Company seeks to grow its specialty managed healthcare business through the following initiatives:

Expanding the radiology benefits management services business. The Company entered the RBM business through its acquisition of NIA on January 31, 2006. Since that time, the Company has embarked on its strategy of expanding NIA's current product offering into risk-based products. The Company has leveraged its information systems, call center, and claims infrastructure as well as its financial strength and underwriting expertise to facilitate the expansion into risk-based RBM products.

In that regard, the Company has modified its claims system, developed and continues to expand a proprietary network of providers, and upgraded its call centers. During 2007, the Company implemented its first two risk-based contracts. The Company intends to continue marketing its risk-based contracts to current ASO customers as well as to new RBM customers, including through cross-selling to its managed behavioral healthcare and specialty pharmaceutical management customer base.

Expanding the specialty pharmaceutical management business. The Company entered the specialty pharmaceutical management business through its acquisition of ICORE on July 31, 2006. The Company believes it can leverage its operational platform and expertise to expand and enhance ICORE's product offering. The Company intends to cross-sell ICORE's products to its current managed behavioral healthcare and radiology benefits management customer base.

Expanded penetration of products in new or growing markets. The Company seeks to expand its services in new and/or growing markets. In recent years, the Medicaid market has increased its use of specialty managed healthcare services. With Medicaid experience in managed behavioral healthcare, radiology benefits management and specialty pharmaceutical management, the Company believes it is positioned to grow its membership and revenues in the Medicaid market over the long term as a result of its proven expertise in managing these services. The Company also believes that it might be able to expand the use of radiology benefits management into new arenas such as Medicare and/or the direct-to-employer market at some time in the future.

Continued diversification of business. The Company continually evaluates opportunities to enter other specialty healthcare businesses or healthcare services that are complementary to its existing operations, that could accelerate its entrance into new products, and/or that could leverage its existing customer relationships.

The Company's current capital structure provides it with the flexibility to consider potential acquisitions that meet its strategic criteria as a possible means to accomplish its strategic objectives.

Customer Contracts

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. The Company's contracts for managed behavioral healthcare and radiology benefits management services generally provide for payment of a per member per month fee to the Company. See "Risk Factors Risk-Based Products" and " Reliance on Customer Contracts."

The Company's contracts with the State of Tennessee's TennCare program ("TennCare") and with subsidiaries of WellPoint, Inc. ("WellPoint"), each generated revenues that exceeded, in the aggregate, ten percent of revenues for the consolidated Company, for the years ended December 31, 2006 and 2007. See further discussion related to these significant customers in "Risk Factors Reliance on Customer Contracts." In addition, see "Risk Factors Dependence on Government Spending" for discussion of risks to the Company related to government contracts.

Provider Network

Except for certain services provided under the Maricopa Contract (see "Business Managed Behavioral Healthcare"), the Company's managed behavioral healthcare services and EAP treatment services are provided by a contracted network of third-party providers, including psychiatrists, psychologists, other behavioral health professionals, psychiatric hospitals, general medical facilities with psychiatric beds, residential treatment centers and other treatment facilities. The number and type of providers in a particular area depend upon customer preference, site, geographic concentration and demographic composition of the beneficiary population in that area. The Company's managed behavioral healthcare network consists of approximately 75,000 behavioral healthcare providers, including facility locations, providing various levels of care nationwide. The Company's network providers are almost exclusively independent contractors located throughout the local areas in which the Company's customers' beneficiary populations reside. Outpatient network providers work out of their own offices, although the Company's personnel are available to assist them with consultation and other needs.

Non-facility network providers include both individual practitioners, as well as individuals who are members of group practices or other licensed centers or programs. Non-facility network providers typically execute standard contracts with the Company under which they are generally paid on a fee-for-service basis.

Third-party network facilities include inpatient psychiatric and substance abuse hospitals, intensive outpatient facilities, partial hospitalization facilities, community health centers and other community-based facilities, rehabilitative and support facilities and other intermediate care and alternative care facilities or programs. This variety of facilities enables the Company to offer patients a full continuum of care and to refer patients to the most appropriate facility or program within that continuum. Typically, the Company contracts with facilities on a per diem or fee-for-service basis and, in some limited cases, on a "case rate" or capitated basis. The contracts between the Company and inpatient and other facilities typically are for one-year terms and are terminable by the Company or the facility upon 30 to 120 days' notice.

Historically, the Company's radiology benefits management services were provided by a network of third-party providers that are contracted by the customers of the Company to provide such services to the customers' members or enrollees. To support its offering of risk-based arrangements, the Company has developed and continues to expand a proprietary network of providers directly, through the use of its internal networking resources, and indirectly through a network contracting company. Network providers include diagnostic imaging centers, radiology departments of hospitals that provide advanced imaging services on an outpatient basis, and individual physicians or physician groups that own advanced imaging equipment and specialize in certain specific areas of care. The Company contracts with these providers on a fee-for-service basis.

Joint Ventures

Prior to April 11, 2006, Premier Behavioral Systems of Tennessee, LLC ("Premier") was a joint venture in which the Company owned a 50 percent interest. On April 11, 2006, the Company purchased the other 50 percent interest in Premier for $1.5 million, so that Premier is now a wholly-owned subsidiary of the Company.

Premier was formed to manage behavioral healthcare benefits for a certain portion of TennCare. In addition, the Company contracted with Premier to provide certain services to the joint venture. Through 2003, the Company accounted for its investment in Premier using the equity method. Effective December 31, 2003, the Company adopted the Financial Accounting Standards Board's ("FASB") Interpretation No. 46, "Consolidation of Variable Interest Entities, an Interpretation of Accounting Research Bulletin ("ARB") No. 51" ("FIN 46"), under which the Company consolidated the balance sheet of Premier in its consolidated balance sheet as of December 31, 2003. Beginning in 2004, the

Company consolidated the results of operations of Premier in its consolidated statement of income. The creditors (or other beneficial interest holders) of Premier have no recourse to the general credit of the Company.

As of December 31, 2005, the Company owned a 37.5 percent interest in Royal Health Care, LLC ("Royal"). Royal was a managed services organization that received management fees for the provision of administrative, marketing, management and support services to seven managed care organizations. Royal did not provide any services to the Company.

The Company accounted for its investment in Royal using the equity method. Effective February 2, 2006, the Company sold its Royal ownership interest back to Royal in exchange for cash proceeds of $20.5 million. See Note 3 "Acquisitions and Joint Ventures" to the consolidated financial statements set forth elsewhere herein for further information on Royal.

Competition

The Company's business is highly competitive. The Company competes with other healthcare organizations as well as with insurance companies, including health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), third-party administrators ("TPAs"), independent practitioner associations ("IPAs"), multi-disciplinary medical groups, pharmacy benefit managers ("PBMs") and other specialty healthcare and managed care companies. Many of the Company's competitors, particularly certain insurance companies, HMOs and PBM's are significantly larger and have greater financial, marketing and other resources than the Company, and some of the Company's competitors provide a broader range of services. The Company may also encounter competition in the future from new market entrants. In addition, some of the Company's customers that are managed care companies, may seek to provide specialty managed healthcare services directly to their subscribers, rather than by contracting with the Company for such services. Because of these factors, the Company does not expect to be able to rely to a significant degree on price increases to achieve revenue growth, and expects to continue experiencing pricing pressures.

Insurance

The Company maintains a program of insurance coverage for a broad range of risks in its business. The Company has renewed its general, professional and managed care liability insurance policies with unaffiliated insurers for a one-year period from June 17, 2007 to June 17, 2008. The general liability policies are written on an "occurrence" basis, subject to a $0.1 million per claim un-aggregated self-insured retention. The professional liability and managed care errors and omissions liability policies are written on a "claims-made" basis, subject to a $1.0 million per claim ($10.0 million per class action claim) un-aggregated self-insured retention for managed care liability, and a $0.1 million per claim un-aggregated self-insured retention for professional liability.

The Company maintains separate general and professional liability insurance policies with an unaffiliated insurer for its Specialty Pharmaceutical Management business. The Specialty Pharmaceutical Management insurance policies have a one-year term for the period June 17, 2007 to June 17, 2008. The general liability policies are written on an "occurrence" basis, subject to a $0.05 million per claim un-aggregated self-insured retention. The professional liability policy is written on a "claims-made" basis, subject to a $0.05 million per claim un-aggregated self-insured retention.

The Company maintains separate general and professional liability insurance policies with an unaffiliated insurer for its Maricopa Contract business, which include coverage for the behavioral health direct care facilities. The Maricopa Contract insurance policies have a one-year term for the period August 31, 2007 to September 1, 2008. The general liability policies are written on an "occurrence" basis, subject to a $0.35 million per claim un-aggregated self-insured retention. The professional liability policy is written on a "claims-made" basis, subject to a $0.35 million per claim un-aggregated self-insured retention.

The Company is responsible for claims within its self-insured retentions, and for portions of claims reported after the expiration date of the policies if they are not renewed, or if policy limits are exceeded. The Company also purchases excess liability coverage in an amount that management believes to be reasonable for the size and profile of the organization. See "Risk Factors Professional Liability and Other Insurance," for a discussion of the risks associated with the Company's insurance coverage.

Regulation

General. The specialty managed healthcare industry is subject to extensive and evolving state and federal regulation. The Company is subject to certain state laws and regulations, including those governing the licensing of insurance companies, HMOs, PPOs, TPAs, companies engaged in utilization review and specialty pharmaceutical management. In addition, the Company is subject to regulations concerning the licensing of healthcare professionals, including restrictions on business corporations from providing, controlling or exercising excessive influence over healthcare services through the direct employment of physicians, psychiatrists or, in certain states, psychologists and other healthcare professionals. These laws and regulations vary considerably among states and the Company may be subject to different types of laws and regulations depending on the specific regulatory approach adopted by each state to regulate the managed care and specialty pharmacy businesses and the provision of healthcare treatment services. In addition, the Company is subject to certain federal laws as a result of the role it assumes in connection with managing its customers' employee benefit plans. The regulatory scheme generally applicable to the Company's operations is described in this section.

The Company believes its operations are structured to comply in all material respects with applicable laws and regulations and that it has received all licenses and approvals that are material to the operation of its business. However, regulation of the specialty managed healthcare industry is constantly evolving, with new legislative enactments and regulatory initiatives at the state and federal levels being implemented on a regular basis. Consequently, it is possible that a court or regulatory agency may take a position under existing or future laws or regulations, or as a result of a change in the interpretation thereof, that such laws or regulations apply to the Company in a different manner than the Company believes such laws or regulations apply. Moreover, any such position may require significant alterations to the Company's business operations in order to comply with such laws or regulations, or interpretations thereof. Expansion of the Company's business to cover additional geographic areas, to serve different types of customers, to provide new services or to commence new operations could also subject the Company to additional license requirements and/or regulation. Failure to comply with applicable regulatory requirements could have a material adverse affect on the Company.

Licenses. Certain regulatory agencies having jurisdiction over the Company possess discretionary powers when issuing or renewing licenses or granting approval of proposed actions such as mergers, a change in ownership, transfer or assignment of licenses and certain intra-corporate transactions. One or multiple agencies may require as a condition of such license or approval that the Company cease or modify certain of its operations or modify the way it operates in order to comply with applicable regulatory requirements or policies. In addition, the time necessary to obtain a license or approval varies from state to state, and difficulties in obtaining a necessary license or approval may result in delays in the Company's plans to expand operations in a particular state and, in some cases, lost business opportunities. In recent years, in response to governmental agency inquiries or discussions with regulators, the Company has determined to seek licensing for its managed behavioral healthcare and radiology benefits management business as a single service HMO, TPA or utilization review agent in one or more jurisdictions. Compliance activities, mandated changes in the Company's operations, delays in the expansion of the Company's business or lost business opportunities as a result of regulatory requirements or policies could have a material adverse effect on the Company. As discussed below, the

Company is subject to certain state licensure requirements in relation to its specialty pharmaceutical management business.

Insurance, HMO and PPO Activities. To the extent that the Company operates or is deemed to operate in some states as an insurance company, HMO, PPO or similar entity, it may be required to comply with certain laws and regulations that, among other things, may require the Company to maintain certain types of assets and minimum levels of deposits, capital, surplus, reserves or net worth. In many states, entities that assume risk under contracts with licensed insurance companies or HMOs have not been considered by state regulators to be conducting an insurance or HMO business. As a result, the Company has not sought licenses as either an insurer or HMO in certain states. The National Association of Insurance Commissioners (the "NAIC") has undertaken a comprehensive review of the regulatory status of entities arranging for the provision of healthcare services through a network of providers that, like the Company, may assume risk for the cost and quality of healthcare services, but that are not currently licensed as an HMO or similar entity. As a result of this review, the NAIC developed a "health organizations risk-based capital" formula, designed specifically for managed care organizations, that establishes a minimum amount of capital necessary for a managed care organization to support its overall operations, allowing consideration for the organization's size and risk profile. The NAIC also adopted a model regulation in the area of health plan standards, which could be adopted by individual states in whole or in part, and could result in the Company being required to meet additional or new standards in connection with its existing operations. Certain states, for example, have adopted regulations based on the NAIC initiative, and as a result, the Company has been subject to certain minimum capital requirements in those states. Certain other states, such as Maryland, Texas, New York and New Jersey, have also adopted their own regulatory initiatives that subject entities such as certain of the Company's subsidiaries to regulation under state insurance laws. This includes, but is not limited to, requiring adherence to specific financial solvency standards. State insurance laws and regulations may limit the Company's ability to pay dividends, make certain investments and repay certain indebtedness. Being licensed as an insurance company, HMO or similar entity could also subject the Company to regulations governing reporting and disclosure, mandated benefits, rate setting and other traditional insurance regulatory requirements. PPO regulations to which the Company may be subject may require the Company to register with a state authority and provide information concerning its operations, particularly relating to provider and payor contracting. The imposition of such requirements could increase the Company's cost of doing business and could delay the Company's conduct or expansion of its business in some areas. The licensing process under state insurance laws can be lengthy and, unless the applicable state regulatory agency allows the Company to continue to operate while the licensing process is ongoing, the Company could experience a material adverse effect on its operating results and financial condition while its license application is pending. In addition, failure to obtain and maintain required licenses typically also constitutes an event of default under the Company's contracts with its customers. The loss of business from one or more of the Company's major customers as a result of such an event of default or otherwise could have a material adverse effect on the Company.

Regulators may impose operational restrictions on entities granted licenses to operate as insurance companies or HMOs. For example, the California Department of Managed Health Care has imposed certain restrictions on the ability of the Company's California subsidiaries to fund the Company's operations in other states, to guarantee or co-sign for the Company's financial obligations, or to pledge or hypothecate the stock of these subsidiaries and on the Company's ability to make certain operational changes with respect to these subsidiaries. In addition, regulators of certain of the Company's subsidiaries may exercise certain discretionary rights under regulations including, without limitation, increasing its supervision of such entities, requiring additional restricted cash or other security.

Utilization Review and Third-Party Administrator Activities. Numerous states in which the Company does business have adopted regulations governing entities engaging in utilization review and TPA

activities. Utilization review regulations typically impose requirements with respect to the qualifications of personnel reviewing proposed treatment, timeliness and notice of the review of proposed treatment and other matters. TPA regulations typically impose requirements regarding claims processing and payments and the handling of customer funds. Utilization review and TPA regulations may increase the Company's cost of doing business in the event that compliance requires the Company to retain additional personnel to meet the regulatory requirements and to take other required actions and make necessary filings. Although compliance with utilization review regulations has not had a material adverse effect on the Company, there can be no assurance that specific regulations adopted in the future would not have such a result, particularly since the nature, scope and specific requirements of such provisions vary considerably among states that have adopted regulations of this type.

Numerous states require the licensing or certification of entities performing utilization review or TPA activities. However, certain federal courts have held that such licensing requirements are preempted by the Employment Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA preempts state laws that mandate employee benefit structures or their administration, as well as those that provide alternative enforcement mechanisms. The Company believes that its TPA activities performed for its self-insured employee benefit plan customers are exempt from otherwise applicable state licensing or registration requirements based upon federal preemption under ERISA and have relied on this general principle in determining not to seek licenses for certain of the Company's activities in many states. Existing case law is not uniform on the applicability of ERISA preemption with respect to state regulation of utilization review or TPA activities. There can be no assurance that additional licenses will not be required with respect to utilization review or TPA activities in certain states.

Licensing of Healthcare Professionals. The provision of healthcare treatment services by physicians, psychiatrists, psychologists and other providers is subject to state regulation with respect to the licensing of healthcare professionals. The Company believes that the healthcare professionals who provide healthcare treatment on behalf of or under contracts with the Company and the case managers and other personnel of the health services business are in compliance with the applicable state licensing requirements and current interpretations thereof. However, there can be no assurance that changes in such state licensing requirements or interpretations thereof will not adversely affect the Company's existing operations or limit expansion. With respect to the Company's crisis intervention program, additional licensing of clinicians who provide telephonic assessment or stabilization services to individuals who are calling from out-of-state may be required if such assessment or stabilization services are deemed by regulatory agencies to be treatment provided in the state of such individual's residence. The Company believes that any such additional licenses could be obtained.

Prohibition on Fee Splitting and Corporate Practice of Professions. The laws of some states limit the ability of a business corporation to directly provide, control or exercise excessive influence over healthcare services through the direct employment of physicians, psychiatrists, psychologists, or other healthcare professionals, who are providing direct clinical services. In addition, the laws of some states prohibit physicians, psychiatrists, psychologists, or other healthcare professionals from splitting fees with other persons or entities. These laws and their interpretations vary from state to state and enforcement by the courts and regulatory authorities may vary from state to state and may change over time. The Company believes that its operations as currently conducted are in material compliance with the applicable laws. However, there can be no assurance that the Company's existing operations and its contractual arrangements with physicians, psychiatrists, psychologists and other healthcare professionals will not be successfully challenged under state laws prohibiting fee splitting or the practice of a profession by an unlicensed entity, or that the enforceability of such contractual arrangements will not be limited. The Company believes that it could, if necessary, restructure its operations to comply with changes in the interpretation or enforcement of such laws and regulations, and that such restructuring would not have a material adverse effect on its operations.

Direct Contracting with Licensed Insurers. Regulators in several states in which the Company does business have adopted policies that require HMOs or, in some instances, insurance companies, to contract directly with licensed healthcare providers, entities or provider groups, such as IPAs, for the provision of treatment services, rather than with unlicensed intermediary companies. In such states, the Company's customary model of contracting directly is modified so that, for example, the IPAs (rather than the Company) contract directly with the HMO or insurance company, as appropriate, for the provision of treatment services.

HIPAA. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires the Secretary of the Department of Health and Human Services ("HHS") to adopt standards relating to the transmission, privacy and security of health information by healthcare providers and healthcare plans. Confidentiality and patient privacy requirements are particularly strict in the Company's behavioral managed care business. In connection with HIPAA, the Company initially commissioned a dedicated HIPAA project management office to achieve compliance within the required timeframes. Oversight responsibilities for HIPAA compliance is now being handled by the Company's Corporate Compliance Department. The Company believes it is currently in compliance with the provisions of HIPAA.

Other Significant Privacy Regulation. The privacy regulation under HIPAA generally does not preempt state law except under the following limited circumstances: (i) the privacy rights afforded under state law are contrary to those provided by HIPAA so that compliance with both standards is not possible and (ii) HIPAA's privacy protections are more stringent than the state law in question. Because many states have privacy laws that either provide more stringent privacy protections than those imposed by HIPAA or laws that can be followed in addition to HIPAA, the Company must address privacy issues under HIPAA and state law as well. While the Company has always been required to follow state privacy laws, the Company now has had to review these state laws against HIPAA to determine whether it must comply with standards established by both HIPAA and state law. In addition, HIPAA has created an increased awareness of the issues surrounding privacy, which may generate more state regulatory scrutiny in this area.

Federal Anti-Remuneration/Fraud And Abuse Laws. The federal healthcare Anti-Kickback Statute (the "Anti-Kickback Statute") prohibits, among other things, an entity from paying or receiving, subject to certain exceptions and "safe harbors," any remuneration, directly or indirectly, to induce the referral of individuals covered by federally funded health care programs, or the purchase, or the arranging for or recommending of the purchase, of items or services for which payment may be made in whole, or in part, under Medicare, Medicaid, TRICARE or other federally funded health care programs. Sanctions for violating the Anti-Kickback Statute may include imprisonment, criminal and civil fines and exclusion from participation in the federally funded health care programs. The Anti-Kickback Statute has been interpreted broadly by courts, the Office of Inspector General ("OIG") within the U.S. Department of Health & Human Services ("DHHS"), and other administrative bodies. It also is a crime under the Public Contractor Anti-Kickback Statute, for any person to knowingly and willfully offer or provide any remuneration to a prime contractor to the United States, including a contractor servicing federally funded health programs, in order to obtain favorable treatment in a subcontract. Violators of this law also may be subject to civil monetary penalties.

Federal Statutes Prohibiting False Claims. The Federal False Claims Act imposes civil penalties for knowingly making or causing to be made false claims with respect to governmental programs, such as Medicare and Medicaid, for services not rendered, or for misrepresenting actual services rendered, in order to obtain higher reimbursement. Private individuals may bring *qui tam* or whistle blower suits against providers under the Federal False Claims Act, which authorizes the payment of a portion of any recovery to the individual bringing suit. A few federal district courts recently have interpreted the Federal False Claims Act as applying to claims for reimbursement that violate the Anti-Kickback

Statute under certain circumstances. The Federal False Claims Act generally provides for the imposition of civil penalties and for treble damages, resulting in the possibility of substantial financial penalties for small billing errors. Criminal provisions that are similar to the Federal False Claims Act provide that a corporation may be fined if it is convicted of presenting to any federal agency a claim or making a statement that it knows to be false, fictitious or fraudulent. Even in situations where the Company does not directly provide services to beneficiaries of federally funded health programs and, accordingly, does not directly submit claims to the federal government, it is possible that the Company could nevertheless become involved in a situation where false claim issues are raised based on allegations that it caused or assisted a government contractor in making a false claim.

The Company is subject to certain provisions of the Deficit Reduction Act of 2005 (the "Act"). The Act requires entities that receive $5 million or more in annual Medicaid payments to establish written policies that provide detailed information about the Federal False Claims Act and the remedies thereunder, as well as any state laws pertaining to civil or criminal penalties for false claims and statements, the "whistleblower" protections afforded under such laws, and the role of such laws in preventing and detecting fraud waste and abuse. The written policies are to be disseminated to all employees, contractors and agents which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services; performs billing or coding functions, or is involved in the monitoring of health care provided by the entity. In addition, any such entity that has an employee handbook must include a specific discussion of the federal and state false claims laws, the rights of an employee to be protected as a whistle blower and the entity's policies and procedures for detecting and preventing fraud, waste and abuse.

State Anti-Remuneration/False Claims Law. Several states have laws and/or regulations similar to the federal anti-remuneration and Federal False Claims Act described above. Sanctions for violating these state anti-remuneration and false claims laws may include injunction, imprisonment, criminal and civil fines and exclusion from participation in the state Medicaid programs.

ERISA. Certain of the Company's services are subject to the provisions of ERISA. ERISA governs certain aspects of the relationship between employer-sponsored healthcare benefit plans and certain providers of services to such plans through a series of complex laws and regulations that are subject to periodic interpretation by the Internal Revenue Service ("IRS") and the U.S. Department of Labor. In some circumstances, and under certain customer contracts, the Company may be expressly named as a "fiduciary" under ERISA, or be deemed to have assumed duties that make it an ERISA fiduciary, and thus be required to carry out its operations in a manner that complies with ERISA in all material respects. The Company believes that it is in material compliance with ERISA and that such compliance does not currently have a material adverse effect on its operations, there can be no assurance that continuing ERISA compliance efforts or any future changes to ERISA will not have a material adverse effect on the Company.

Regulation of Customers. Regulations imposed upon the Company's customers include, among other things, benefits mandated by statute, exclusions from coverage prohibited by statute, procedures governing the payment and processing of claims, record keeping and reporting requirements, requirements for and payment rates applicable to coverage of Medicaid and Medicare beneficiaries, provider contracting and enrollee rights and confidentiality requirements. Although the Company believes that such regulations do not, at present, materially impair its operations, there can be no assurance that such indirect regulation will not have a material adverse effect on the Company in the future.

Other Regulation of Healthcare Providers. The Company's business is affected indirectly by regulations imposed upon healthcare providers. Regulations imposed upon healthcare providers include but are not limited to, provisions relating to the conduct of, and ethical considerations involved in, the practice of psychiatry, psychology, social work and related behavioral healthcare professions, radiology,

pharmacy, accreditation, government healthcare program participation requirements, reimbursements for patient services, Medicare and Medicaid fraud and abuse and, in certain cases, the common law duty to warn others of danger or to prevent patient self-injury. Changes in these regulatory requirements applicable to healthcare providers could impact the Company's business methods and practices and there can be no assurances that the impact would not be adverse and material.

Additional Regulation Affecting the Specialty Pharmaceutical Management segment. With the Company's acquisition of ICORE, additional federal and state regulations became applicable to the Company. Various aspects of the Company's specialty pharmaceutical management business are governed by federal and state laws and regulations not previously applicable to the Company or which may now be applicable in different ways. There are significant uncertainties involving the application of many of these legal requirements to the Company.

OIG Compliance Program Guidance for Pharmaceutical Manufacturers. In April 2003, the OIG published "Final OIG Compliance Program Guidance for Pharmaceutical Manufacturers," ("Compliance Guidance"). The Compliance Guidance is voluntary and is directly aimed at the compliance efforts of pharmaceutical manufacturers. This Compliance Guidance highlights several transactions as potential "risks," including transactions and relationships with PBMs, some of which are similar to transactions and/or relationships that the Company enters into with its customers.

Medicare Prescription Drug, Improvement and Modernization Act of 2003. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, ("MMA") that took effect on January 1, 2006, among other things, created a new voluntary outpatient prescription drug benefit for Medicare enrollees on an insured basis through Prescription Drug Plans, ("PDPs"), and by Medicare Advantage Plans ("Part D Activities"), in various regions across the United States. Among other things, PDPs and Medicare Advantage Plans are subject to provisions of the MMA intended to deter fraud, waste and abuse and are monitored strictly by CMS and its contracted Medicare Drug Integrity Contractors ("MEDICs") to ensure that Part D program funds are not spent inappropriately. If CMS determines that the Company has not performed satisfactorily as a subcontractor, CMS may request a PDP or a Medicare Advantage Plan customer of the Company to revoke its Part D activities or responsibilities under the subcontract.

FDA Regulation. The U.S. Food and Drug Administration ("FDA") generally has authority to regulate drug promotional materials that are disseminated "by or on behalf of" a drug manufacturer. The Company's business includes the provision of educational seminars for prescribers and other of the Company's customers on behalf of manufacturer clients and thus is subject to the federal laws applicable to the promotion of prescription drugs.

State Comprehensive PBM Regulation. States continue to introduce broad legislation to regulate pharmacy benefits management activities. Some of this legislation could encompass the activities of the Company. In particular, such legislation seeks to impose fiduciary duties or disclosure obligations on entities that provide certain types of pharmacy management services. Both Maine and the District of Columbia have enacted statutes imposing fiduciary obligations on entities providing pharmacy management services.

State Legislation Affecting Plan Or Benefit Design. Some states have enacted legislation that prohibits certain types of managed care plan sponsors from implementing certain restrictive formulary and network design features, and many states have legislation regulating various aspects of managed care plans, including provisions relating to the pharmacy benefits. Other states mandate coverage of certain benefits or conditions and require health plan coverage of specific drugs, if deemed medically necessary by the prescribing physician. Such legislation does not generally apply to the Company directly, but may apply to certain clients of the Company, such as HMOs and health insurers.

Legislation Affecting Drug Prices. Under MMA, Medicare Part B drugs generally are reimbursed on an "average sales price" ("ASP") methodology. This ASP methodology may create an incentive for some drug manufacturers to reduce the levels of discounts or rebates available to purchasers, including the Company, or their clients with respect to Medicare Part B drugs.

The federal Medicaid rebate statute provides that pharmaceutical manufacturers of brand-name outpatient prescription drugs must provide the Medicaid program a rebate in accordance with certain requirements. Investigations have been commenced by certain government agencies which question whether Medicaid rebates were properly calculated in accordance with such requirements, reported and paid by the manufacturers to the Medicaid programs. The Company is not responsible for such calculations, reports or payments, but changes in this area could materially and adversely affect its business.

Regulations Affecting the Company's Pharmacies. The Company owns two pharmacies that provide services to certain of the Company's health plan customers. The activities undertaken by the Company's pharmacies subject the pharmacies to state and federal statutes and regulations governing, among other things, the licensure and operation of mail order and non-resident pharmacies, repackaging of drug products, stocking of prescription drug products and dispensing of prescription drug products, including controlled substances. The Company's pharmacy facilities are located in Florida and New York and are duly licensed to conduct business in those states. Many states, however, require out-of-state mail order pharmacies to register with or be licensed by the state board of pharmacy or similar governing body when pharmaceuticals are delivered by mail into the state and some states require that an out-of-state pharmacy employ a pharmacist that is licensed in the state into which pharmaceuticals are shipped. The Company holds mail order and non-resident pharmacy licenses where required.

Regulation of Controlled Substances. The Company's pharmacies must register with the United States Drug Enforcement Administration (the "DEA"), and individual state controlled substance authorities in order to dispense controlled substances. Federal law requires the Company to comply with the DEA's security, recordkeeping, inventory control, and labeling standards in order to dispense controlled substances. State controlled substance law requires registration and compliance with state pharmacy licensure, registration or permit standards promulgated by the state pharmacy licensing authority.

Some of the state regulatory requirements described above may be preempted in whole or in part by ERISA, which provides for comprehensive federal regulation of employee benefit plans. However, the scope of ERISA preemption is uncertain and is subject to conflicting court rulings. As a result, the Company could be subject to overlapping federal and state regulatory requirements in respect of certain of its operations and may need to implement compliance programs that satisfy multiple regulatory regimes.

Other. Most of the Company's distribution contracts with its customers use "average wholesale price" ("AWP") as a benchmark for establishing pricing. As part of a proposed settlement in the case of New England Carpenters Health Benefit Fund, et. al. v. First Data Bank, et. al., Civil Action No. 1:05-CV-11148-PBS (D. Mass.), a case brought against First Data Bank, one of several companies that report data on prescription drug prices, First Data Bank has agreed to reduce the AWP of over 8,000 specific pharmaceutical products by four percent. The proposed settlement received preliminary but not final approval of the court, but at a fairness hearing on January 23, 2008, the court denied approval of the settlement without prejudice. The Company cannot predict whether or when the parties will attempt to cure any deficiencies identified by the court and resubmit the settlement for approval.

In the absence of any action on the part of the Company to renegotiate with its customers the pricing of those pharmaceutical distribution contracts that use AWP, a settlement that involves a reduction in First Data Bank's AWP could adversely affect the margin earned on those distribution contracts that use AWP, however it is not expected to have a material adverse affect on the Company's results of operations.

Other Proposed Legislation. In the last five years, legislation has periodically been introduced at the state and federal levels providing for new healthcare regulatory programs and materially revising existing healthcare regulatory programs. Recently some states including Massachusetts, Maryland and California have enacted or are considering legislation regarding various forms of mandatory or universal health insurance coverage. The proposed California legislation also contains provisions relating to minimum medical loss ratios. Such legislation could include both federal and state bills affecting Medicaid programs which may be pending in, or recently passed by, state legislatures and which are not yet available for review and analysis. Such legislation could also include proposals for national health insurance or state-based mandatory universal health insurance coverage and other forms of federal and state regulation of health insurance and healthcare delivery.

In addition, behavioral health parity legislation is being considered in Congress and could have an impact on the Company should such legislation pass. The legislation seeks to establish parity in financial requirements (e.g. copays, deductibles, etc.) and treatment limitations between mental health benefits and medical/surgical benefits for members.

It is not possible at this time to predict whether any of the legislation discussed above will be adopted at the federal or state level, or the nature, scope or applicability to the Company's business of any such legislation, or when any particular legislation might be implemented. No assurance can be given that any such federal or state legislation will not have a material adverse effect on the Company. However, the Company's risk contracts do allow for repricing to occur effective the same date that any legislation becomes effective if that legislation is projected to have a material affect on cost of care.

Employees of the Registrant

At December 31, 2007, the Company had approximately 5,600 full-time and part-time employees. The Company believes it has satisfactory relations with its employees.

History

Prior to 1997, the Company's primary business was the operation of psychiatric hospitals. In addition, the Company operated, through its human services segment, specialty home-based healthcare services. In late 1997 and early 1998, the Company completed its acquisition of Green Spring Health Services, Inc., purchased Human Affairs International, Incorporated, and acquired Merit Behavioral Care Corporation, which were three of the largest managed behavioral healthcare organizations and sold most of its psychiatric hospitals and entered into a franchise arrangement with the buyer. In September 1999, the Company completed its exit from the psychiatric hospital provider and franchising businesses and in March 2001 sold National Mentor, Inc. ("Mentor"), which represented the business and interests which comprised the Company's human services segment. As a result of these transactions, the Company's sole business through 2005 was the managed behavioral healthcare business.

Due primarily to the debt-financed acquisitions noted above, and the subsequent disposal activities, the Company had amassed over $1.0 billion in total debt as of September 30, 2002. The Company concluded that it could no longer support the existing capital structure and determined to restructure its debt to levels that were more in line with its operations. On March 11, 2003 (the "Commencement Date"), Magellan and 88 of its subsidiaries filed voluntary petitions for relief under chapter 11 of title 11 of the United States Bankruptcy Code (the "Bankruptcy Code"), in order to accomplish such restructuring.

On January 5, 2004 (the "Effective Date"), Magellan and 88 of its subsidiaries consummated their Third Joint Amended Plan of Reorganization, as modified and confirmed (the "Plan"), which had been confirmed by order of the United States Bankruptcy Court for the Southern District of New York (the

"Bankruptcy Court") on October 8, 2003, and accordingly the Plan became fully effective and the companies emerged from the protection of their chapter 11 proceedings.

Giving effect to the Plan, Magellan and its subsidiaries continued, in their previous organizational form, to conduct their business as previously conducted, with the same assets in all material respects, but the Company was recapitalized. Under the Plan, the Company's senior secured bank indebtedness under its previous credit agreement (the "Old Credit Agreement"), as existing before the Effective Date, was paid in full, and other then-existing indebtedness (i.e., 9.375% senior notes due 2007 (the "Old Senior Notes"), 9% Senior Subordinated Notes due 2008 in the principal amount of $625.0 million (the "Old Subordinated Notes") and other general unsecured creditor claims ("Other GUCs")) and the then-existing equity interests in Magellan were cancelled as of the Effective Date in exchange for the distributions provided for by the Plan, all as of the Effective Date.

All distributions were made as of the Effective Date except for distributions related to disputed claims for Other GUCs, for which distributions were made subsequent to the Effective Date periodically as such disputed claims were settled. As of December 31, 2007, the total amount of outstanding, disputed claims for Other GUCs is $2.8 million ("Disputed Claims"). The Company does not believe that it is probable that any liability for the Disputed Claims will be incurred, and thus no liability has been recorded for the Disputed Claims as of December 31, 2007. Nonetheless, the Company has withheld from distribution 89,798 shares of Ordinary Common Stock (the "Reserved Shares") which will be distributed in accordance with the terms of the Plan upon the final resolution of the Disputed Claims. If the Disputed Claims were to be resolved for the full amount of $2.8 million, then the amount of additional consideration, in addition to the Reserved Shares, that the Company would be required to issue to the individual claimants that filed the Disputed Claims is cash of $0.7 million. If the Disputed Claims are resolved for less than $2.8 million, some or all of the Reserved Shares will be distributed as an incremental distribution to Other GUCs whose claims have been allowed in the bankruptcy.

An affiliate of Onex Corporation, a Canadian corporation, ("Onex"), in connection with the Plan, purchased approximately 8.5 million shares of common stock of Magellan in the form of shares of Multi-Vote Common Stock. During 2005, Onex disposed of all of its holdings in the Company, and therefore all of the outstanding Multi-Vote Common Stock converted into Ordinary Common Stock.

On January 19, 2005, the Bankruptcy Court entered a final decree closing the chapter 11 case.

Available Information

The Company makes its annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934, and Section 16 filings available, free of charge, on the Company's website at www.magellanhealth.com as soon as practicable after the Company has electronically filed such material with, or furnished it to, the Securities and Exchange Commission ("SEC"). The information on the Company's website is not part of or incorporated by reference in this report on Form 10-K.

Item 1A. Risk Factors

Reliance on Customer Contracts The Company's inability to renew, extend or replace expiring or terminated contracts could adversely affect the Company's liquidity, profitability and financial condition.

Substantially all of the Company's net revenue is derived from contracts that may be terminated immediately with cause and many, including some of the Company's most significant contracts, are terminable without cause by the customer upon notice and the passage of a specified period of time

(typically between 60 and 180 days), or upon the occurrence of certain other specified events. The Company's ten largest customers accounted for 74.9 percent and 65.9 percent of the Company's net revenue in the years ended December 31, 2006 and 2007, respectively. Loss of all of these contracts or customers would, and loss of any one of these contracts or customers could, materially reduce the Company's net revenue and have a material adverse effect on the Company's liquidity, profitability and financial condition.

The Company's contracts with TennCare and with subsidiaries of WellPoint each generated revenues that exceeded, in the aggregate, ten percent of revenues for the consolidated Company for the years ended December 31, 2006 and 2007. Revenues from the Company's contracts with TennCare exceeded ten percent of managed behavioral healthcare net revenues for the years ended December 31, 2006 and 2007. The Company's contracts with subsidiaries of WellPoint generated revenues that exceeded, in the aggregate, ten percent of managed behavioral healthcare net revenues for the year ended December 31, 2006, and ten percent of radiology benefits management net revenues for the years ended December 31, 2006 and 2007.

The Company provides managed behavioral healthcare services for TennCare through contracts that extend through June 30, 2008. The TennCare program is divided into three regions, and through March 31, 2007 the Company's TennCare contracts encompassed all of the TennCare membership for all three regions.

As of April 1, 2007 substantially all of the membership in the Middle Grand Region was re-assigned to managed care companies in accordance with contract awards by TennCare pursuant to its request for proposals ("RFPs") for the management of the integrated delivery of behavioral and physical medical care to the region. The Company continues to manage behavioral healthcare services for approximately 19,000 children in the Middle Grand Region enrolled in TennCare's Select, DCS Custody and SSI Children categories on substantially the same terms previously applicable to the entire region. Additionally, the Company continues to manage behavioral healthcare services for approximately 10,000 adults on substantially the same basis, continuing only until TennCare disenrolls them as a result of eligibility changes that were enacted in late 2005. The Company recorded revenue of $416.4 million and $316.9 million during the years ended December 31, 2006 and 2007, respectively, from its TennCare contracts.

In January 2008 TennCare issued an RFP for the management by managed care organizations of the integrated delivery of behavioral and physical medical care to TennCare enrollees in the East Grand and West Grand Regions. The RFP sets forth intended start dates of November 1, 2008 for the West Grand Region and January 1, 2009 for the East Grand Region. TennCare has indicated that it intends to award contracts to at least two managed care organizations in each of the East Grand and West Grand Regions. The Company intends to bid with Coventry Health Care, Inc. ("Coventry") on the RFP through a subcontract agreement under which the Company would manage the behavioral healthcare benefits for any contract awarded to Coventry pursuant to the RFP. Because the Company is aligned with only one managed care organization, even if successful in the bid process, the Company would not retain a significant portion of the membership that it currently serves. There can be no assurance that Coventry will be awarded a contract with TennCare; or that if Coventry is awarded a contract pursuant to the RFP, the terms of the subcontract will be similar to terms the Company currently has with TennCare. The Company anticipates that in any event it will continue to manage TennCare's Select, DCS Custody and SSI Children in both the East and West Grand Regions, as well as continuing to manage them in the Middle Grand Region. The statewide membership, including the 19,000 children in the Middle Grand Region stated above, is approximately 59,000 lives for this population. However, there can be no assurance that TennCare will continue to contract with the Company for management of such recipients.

Total revenue from the Company's contracts with WellPoint was $200.2 million and $218.9 million during the years ended December 31, 2006 and 2007, respectively, including radiology benefits management revenue of $12.6 million and $77.8 million, during the years ended December 31, 2006 and 2007, respectively. One of the Company's managed behavioral healthcare contracts with WellPoint was terminated by WellPoint effective March 31, 2007, and generated revenue of $26.0 million during 2007. A second managed behavioral healthcare contract with WellPoint expired December 31, 2007 and generated revenue of $85.7 million during the year ended December 31, 2007.

In July 2007, WellPoint acquired a radiology benefits management company, and has expressed its intent to in-source all of its radiology benefits management contracts when such contracts expire. The Company has several radiology benefits management contracts with WellPoint including one that converted from an ASO arrangement to a risk arrangement effective July 1, 2007. Such risk contract has a three-year term through June 30, 2010, and cannot be terminated early, except for cause, as defined in the agreement. The Company's other radiology benefits management contracts with WellPoint generated $16.1 million of revenue for the year ended December 31, 2007. Of this amount, $13.4 million relates to contracts that have terms through various dates in 2008, and the remainder has a term through June 30, 2010.

In addition to TennCare, one other customer represented greater than ten percent of the net revenues in the Company's managed behavioral healthcare business for the year ended December 31, 2007, generating $196.1 million of net revenues in 2007.

The Company derives a significant portion of its managed behavioral healthcare revenue from contracts with various counties in the State of Pennsylvania (the "Pennsylvania Counties"). Although these are separate contracts with individual counties, they all pertain to the Pennsylvania Medicaid program. Revenues from the Pennsylvania Counties in the aggregate totaled $248.2 million and $262.6 million for the years ended December 31, 2006 and 2007, respectively.

In addition to WellPoint, two other customers generated greater than ten percent of the net revenues in the Company's radiology benefits management business for the year ended December 31, 2006, generating $5.2 million and $4.8 million of net revenues in 2006. In addition to WellPoint, one other customer generated greater than ten percent of the net revenues in the Company's radiology benefits management business for the year ended December 31, 2007. Such customer generated $61.3 million of net revenues for the year ended December 31, 2007.

Included in the Company's specialty pharmaceutical management business are three customers that each exceeded ten percent of the net revenues for this line of business for the year ended December 31, 2006. The three customers generated $24.8 million, $11.7 million and $9.6 million of net revenues in 2006. Included in the Company's specialty pharmaceutical management business are four customers that each exceeded ten percent of the net revenues for this line of business for the year ended December 31, 2007. The four customers generated $60.0 million, $34.4 million, $33.6 million and $24.9 million of net revenues in 2007.

Integration of Companies Acquired by Magellan The Company's profitability could be adversely affected if the integration of companies acquired by Magellan, including NIA and ICORE, is not completed in a timely and effective manner.

As previously discussed, one of the Company's growth strategies is to make strategic acquisitions which are complementary to its existing operations. NIA and ICORE are the first such acquisitions completed by the Company. After Magellan closes on an acquisition, it must integrate the acquired company into Magellan's polices, procedures and systems. Failure to effectively integrate an acquired business could result in excessive costs being incurred, a delay in obtaining targeted synergies, decreased customer performance (which could result in contract penalties and/or terminations), increased employee turnover, and lost sales opportunities.

Changes in the Medical Managed Care Carve-Out Industry Certain changes in the business practices of this industry could negatively impact the Company's resources, profitability and results of operations.

Substantially all of the Company's Health Plan, Radiology Benefits Management and Specialty Pharmaceutical Management segment net revenue is derived from customers in the medical managed care industry, including managed care companies, health insurers and other health plans. Some types of changes in this industry's business practices could negatively impact the Company. For example, if the Company's managed care customers seek to provide services directly to their subscribers, instead of contracting with the Company for such services, the Company could be adversely affected. In this regard, Aetna, Inc. ("Aetna") and WellPoint had decided to provide managed behavioral services directly to some or all of their subscribers, which resulted in the December 31, 2005 termination of the Aetna contract, and the terminations of one contract with WellPoint on March 31, 2007 and a second WellPoint contract on December 31, 2007. In addition to Aetna and WellPoint, other managed care customers of the Company did not renew all or part of their contracts with the Company during 2006 and 2007, and instead provided managed behavioral healthcare services directly to their subscribers. Other of the Company's customers that are managed care companies could also seek to provide services directly to their subscribers, rather than by contracting with the Company for such services. In addition, the Company has a significant number of contracts with Blue Cross Blue Shield plans and other regional health plans. Consolidation of the healthcare industry through acquisitions and mergers could potentially result in the loss of contracts for the Company. Any of these changes could reduce the Company's net revenue, and adversely affect the Company's profitability and financial condition.

Changes in the Contracting Model for Medicaid Contracts Certain changes in the contracting model used by states for managed healthcare services contracts relating to Medicaid lives could negatively impact the Company's resources, profitability and results of operations.

Substantially all of the Company's Public Sector segment net revenue is derived from direct contracts that it has with state or county governments for the provision of services to Medicaid enrollees. In addition to TennCare discussed above, certain other states have recently contracted with managed care companies to manage both the behavioral and physical medical care of its Medicaid enrollees. If other governmental entities change the method for contracting for Medicaid business to a fully integrated model, the Company will attempt to subcontract with the managed care organizations to provide behavioral healthcare management for such Medicaid business; however, there is no assurance that the Company would be able to secure such arrangements. Accordingly, if such a change in the contracting model were to occur, it is possible that the Company could lose current contracted revenues, as well as be unable to bid on potential new business opportunities, thus negatively impacting the Company's profitability and financial condition.

Risk-Based Products Because the Company provides services at a fixed fee, if the Company is unable to accurately predict and control healthcare costs, the Company's profitability could decline.

The Company derives its net revenue primarily from arrangements under which the Company assumes responsibility for costs of treatment in exchange for a fixed fee. The Company refers to such arrangements as "risk-based contracts" or "risk-based products," which includes EAP services. These arrangements provided 85.3 percent and 82.4 percent of the Company's net revenue in the years ended December 31, 2006 and 2007, respectively.

Profitability of the Company's risk contracts could be reduced if the Company is unable to accurately estimate the rate of service utilization by members or the cost of such services when the Company prices its services. The Company's assumptions of utilization and costs when the Company prices its services may not ultimately reflect actual utilization rates and costs, many aspects of which are beyond the Company's control. If the cost of services provided to members under a contract together

with the administrative costs exceeds the aggregate fees received by the Company under such contract, the Company will incur a loss on the contract.

The Company's profitability could also be reduced if the Company is required to make adjustments to estimates made in reporting historical financial results regarding cost of care, reflected in the Company's financial statements as medical claims payable. Medical claims payable includes reserves for incurred but not reported ("IBNR") claims, which are claims for covered services rendered by the Company's providers which have not yet been submitted to the Company for payment. The Company estimates and reserves for IBNR claims based on past claims payment experience, including the average interval between the date services are rendered and the date the claims are received and between the date services are rendered and the date claims are paid, enrollment data, utilization statistics, adjudication decisions, authorized healthcare services and other factors. This data is incorporated into contract-specific reserve models. The estimates for submitted claims and IBNR claims are made on an accrual basis and adjusted in future periods as required. The Company currently possesses a limited amount of experience related to underwriting risk-based RBM products. If such risk-based RBM products are not correctly underwritten, the Company's profitability and financial condition could be adversely affected.

Factors that affect the Company's ability to price the Company's services, or accurately make estimates of IBNR claims and other expenses for which the Company creates reserves may include differences between the Company's assumptions and actual results arising from, among other things:

changes in the delivery system;

changes in utilization patterns;

changes in the number of members seeking treatment;

unforeseen fluctuations in claims backlogs;

unforeseen increases in the costs of the services;

the occurrence of catastrophes;

regulatory changes; and

changes in benefit plan design.

Some of these factors could impact the ability of the Company to manage and control the medical costs to the extent assumed in the pricing of its services.

If the Company's membership in risk-based business continues to grow (which is a major focus of the Company's strategy), the Company's exposure to potential losses from risk-based products will also increase.

Fluctuation in Operating Results The Company experiences fluctuations in quarterly operating results and, as a consequence, the Company may fail to meet or exceed market expectations, which could cause the Company's stock price to decline.

The Company's quarterly operating results have varied in the past and may fluctuate significantly in the future due to seasonal and other factors, including:

changes in utilization levels by enrolled members of the Company's risk-based contracts, including seasonal utilization patterns (for example, members generally tend to seek services less during the third and fourth quarters of the year than in the first and second quarters of the year);

performance-based contractual adjustments to net revenue, reflecting utilization results or other performance measures;

changes in estimates for contractual adjustments under commercial contracts;

retrospective membership adjustments;

the timing of implementation of new contracts and enrollment changes; and

changes in estimates regarding medical costs and IBNR claims.

These factors may affect the Company's quarterly and annual net revenue, expenses and profitability in the future and, accordingly, the Company may fail to meet market expectations, which could cause the Company's stock price to decline.

Dependence on Government Spending The Company can be adversely affected by changes in federal, state and local healthcare policies.

All of the Company's Public Sector segment net revenue and a portion of the Company's net revenue in the Company's other four operating segments are derived, directly or indirectly, from governmental agencies, including state Medicaid programs. Contract rates vary from state to state, are subject to periodic negotiation and may limit the Company's ability to maintain or increase rates. The Company is unable to predict the impact on the Company's operations of future regulations or legislation affecting Medicaid programs, or the healthcare industry in general, and future regulations or legislation may have a material adverse effect on the Company. Moreover, any reduction in government spending for such programs could also have a material adverse effect on the Company (See "Reliance on Customer Contracts"). In addition, the Company's contracts with federal, state and local governmental agencies, under both direct contract and subcontract arrangements, generally are conditioned upon financial appropriations by one or more governmental agencies, especially in the case of state Medicaid programs. These contracts generally can be terminated or modified by the customer if such appropriations are not made. Finally, some of the Company's contracts with federal, state and local governmental agencies, under both direct contract and subcontract arrangements, require the Company to perform additional services if federal, state or local laws or regulations imposed after the contract is signed so require, in exchange for additional compensation to be negotiated by the parties in good faith. Government and other third-party payors generally seek to impose lower contract rates and to renegotiate reduced contract rates with service providers in a trend toward cost control.

Restrictive Covenants in the Company's Debt Instruments Restrictions imposed by the Company's debt agreements limit the Company's operating and financial flexibility. These restrictions may adversely affect the Company's ability to finance the Company's future operations or capital needs or engage in other business activities that may be in the Company's interest.

The Company's credit agreement with Deutsche Bank dated January 5, 2004, as amended (the "Credit Agreement"), contains a number of covenants. These covenants limit Company 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;

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 Credit Agreement also requires the Company to comply with specified financial ratios and tests. Failure to do so, unless waived by the lenders under the Credit Agreement, pursuant to its terms, would result in an event of default under the Credit Agreement. The Credit Agreement is guaranteed by most of the Company's subsidiaries and is secured by most of the Company's assets and the Company's subsidiaries' assets.

Required Assurances of Financial Resources The Company's liquidity, financial condition, prospects and profitability can be adversely affected by present or future state regulations and contractual requirements that the Company provide financial assurance of the Company's ability to meet the Company's obligations.

Some of the Company's contracts and certain state regulations require the Company or certain of the Company's subsidiaries to maintain specified cash reserves or letters of credit and/or to maintain certain minimum tangible net equity in certain of the Company's subsidiaries as assurance that the Company has financial resources to meet the Company's contractual obligations. Many of these state regulations also restrict the investment activity of certain of the Company's subsidiaries. Some state regulations also restrict the ability of certain of the Company's subsidiaries to pay dividends to Magellan. Additional state regulations could be promulgated that would increase the cash or other security the Company would be required to maintain. In addition, the Company's customers may require additional restricted cash or other security with respect to the Company's obligations under the Company's contracts, including the Company's obligation to pay IBNR claims and other medical claims not yet processed and paid. In addition, certain of the Company's contracts and state regulations limit the profits that the Company may earn on risk-based business. The Company's liquidity, financial condition, prospects and profitability could be adversely affected by the effects of such regulations and contractual provisions. See Note 2 "Summary of Significant Accounting Policies Restricted Assets" to the consolidated financial statements set forth elsewhere herein for a discussion of the Company's restricted assets.

Competition The competitive environment in the specialty managed healthcare industry may limit the Company's ability to maintain or increase the Company's rates, which would limit or adversely affect the Company's profitability, and any failure in the Company's ability to respond adequately may adversely affect the Company's ability to maintain contracts or obtain new contracts.

The Company's business is highly competitive. The Company competes with other healthcare organizations as well as with insurance companies, including HMOs, PPOs, TPAs, IPAs, multi-disciplinary medical groups, PBMs and other specialty healthcare and managed care companies. Many of the Company's competitors, particularly certain insurance companies, HMOs and PBMs are significantly larger and have greater financial, marketing and other resources than the Company, which can create downward pressure on prices through economies of scale. The entrance or expansion of these larger companies in the specialty managed healthcare industry (including the Company's customers who have insourced or who may choose to insource healthcare services) could increase the competitive pressures the Company faces and could limit the Company's ability to maintain or increase the Company's rates. If this happens, the Company's profitability could be adversely affected. In

addition, if the Company does not adequately respond to these competitive pressures, it could cause the Company to not be able to maintain its current contracts or to not be able to obtain new contracts.

Possible Impact of Healthcare Reform Healthcare reform can significantly reduce the Company's revenues or profitability.

The U.S. Congress and certain state legislatures are considering legislation that, among other things, would limit healthcare plans and methods of operations, limit employers' and healthcare plans' ability to define medical necessity, permit employers and healthcare plans to be sued in state courts for coverage determinations, provide universal health insurance at the state level, provide for minimum medical loss ratios, and otherwise affect health care insurance and managed care. It is uncertain whether the Company could recoup, through higher revenues or other measures, the increased costs of federal or state mandated benefits or other increased costs caused by such legislation or similar legislation. Other federal or state changes in law regarding managed care or universal health insurance coverage could also have adverse consequences for the Company's business. In addition, if any federal parity legislation is adopted and the difference in coverage limits for mental health coverage and medical health coverage is reduced or eliminated, any increase in net revenue the Company derives following such legislation may not be sufficient to cover the increase in costs that would result from a greater utilization of mental healthcare services. The Company cannot predict the effect of this legislation or other legislation that may be adopted by Congress or by the states, and such legislation, if implemented, could have an adverse effect on the Company.

Government Regulation The Company is subject to substantial government regulation and scrutiny, which increase the Company's costs of doing business and could adversely affect the Company's profitability.

The specialty managed healthcare industry and the provision of specialty managed healthcare are subject to extensive and evolving federal and state regulation. Such laws and regulations cover, but are not limited to, matters such as licensure, accreditation, government healthcare program participation requirements, information privacy and security, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. The Company's specialty pharmaceutical management business is also the subject of substantial federal and state governmental regulation and scrutiny. Government investigations and allegations have become more frequent concerning possible violations of fraud and abuse and false claims statutes and regulations by healthcare organizations. Violators may be excluded from participating in government healthcare programs, subject to fines or penalties or required to repay amounts received from the government for previously billed services. A violation of such laws and regulations may have a material adverse effect on the Company.

The Company is subject to certain state laws and regulations and federal laws as a result of the Company's role in management of customers' employee benefit plans.

Regulatory issues may also affect the Company's operations including, but not limited to:

- additional state licenses that may be required to conduct the Company's businesses, including utilization review and TPA activities;
- limits imposed by state authorities upon corporations' control or excessive influence over managed healthcare services through the direct employment of physicians, psychiatrists, psychologists or other professionals, and prohibiting fee splitting;
- laws that impose financial terms and requirements on the Company due to the Company's assumption of risk under contracts with licensed insurance companies or HMOs;
- laws in certain states that impose an obligation to contract with any healthcare provider willing to meet the terms of the Company's contracts with similar providers;

maintaining confidentiality of patient information; and

complying with HIPAA.

The imposition of additional licensing and other regulatory requirements may, among other things, increase the Company's equity requirements, increase the cost of doing business or force significant changes in the Company's operations to comply with these requirements.

The costs associated with compliance with government regulation as discussed above may adversely affect the Company's financial condition and results of operations.

The Company faces additional regulatory risks associated with its Specialty Pharmaceutical Management segment which could subject it to additional regulatory scrutiny and liability and which could adversely affect the profitability of the Specialty Pharmaceutical Management segment in the future.

With the Company's acquisition of ICORE, additional federal and state regulations became applicable to the Company. Various aspects of the Company's Specialty Pharmaceutical Management segment are governed by federal and state laws and regulations not previously applicable to the Company or which may now be applicable in different ways. Significant sanctions may be imposed for violations of these laws and compliance programs are a significant operational requirement of the Company's business. There are significant uncertainties involving the application of many of these legal requirements to the Company. Accordingly, the Company may be required to incur additional administrative and compliance expenses in determining the applicable requirements and in adapting its compliance practices, or modifying its business practices, in order to satisfy changing interpretations and regulatory policies. In addition, there are numerous proposed health care laws and regulations at the federal and state levels, many of which, if adopted, could adversely affect the Company's business.

Federal Anti-Remuneration/Fraud And Abuse Laws.

The federal healthcare Anti-Kickback Statute prohibits, among other things, an entity from paying or receiving, subject to certain exceptions and "safe harbors," any remuneration, directly or indirectly, to induce the referral of individuals covered by federally funded health care programs, or the purchase, or the arranging for or recommending of the purchase, of items or services for which payment may be made in whole, or in part, under Medicare, Medicaid, TRICARE or other federally funded health care programs. Sanctions for violating the Anti-Kickback Statute may include imprisonment, criminal and civil fines and exclusion from participation in the federally funded health care programs. The Anti-Kickback Statute has been interpreted broadly by courts, the OIG within DHHS, and other administrative bodies. It also is a crime under the Public Contractor Anti-Kickback Statute, for any person to knowingly and willfully offer or provide any remuneration to a prime contractor to the United States, including a contractor servicing federally funded health programs, in order to obtain favorable treatment in a subcontract. Violators of this law also may be subject to civil monetary penalties.

In April 2003, the OIG published Compliance Guidance. The Compliance Guidance is voluntary and is directly aimed at the compliance efforts of pharmaceutical manufacturers. This Compliance Guidance highlights several transactions as potential "risks," including transactions and relationships with PBMs, some of which are similar to transactions and/or relationships that the Company enters into with its customers. As pharmaceutical manufacturers' business practices evolve in compliance with the Compliance Guidelines, the Company's relationships with pharmaceutical manufacturers may be adversely affected.

Federal Statutes Prohibiting False Claims.

The Federal False Claims Act imposes civil penalties for knowingly making or causing to be made false claims with respect to governmental programs, such as Medicare and Medicaid, for services not rendered, or for misrepresenting actual services rendered, in order to obtain higher reimbursement. Private individuals may bring *qui tam* or whistle blower suits against providers under the Federal False Claims Act, which authorizes the payment of a portion of any recovery to the individual bringing suit. A few federal district courts recently have interpreted the Federal False Claims Act as applying to claims for reimbursement that violate the Anti-Kickback Statute under certain circumstances. The Federal False Claims Act generally provides for the imposition of civil penalties and for treble damages, resulting in the possibility of substantial financial penalties for small billing errors. Criminal provisions that are similar to the Federal False Claims Act provide that a corporation may be fined if it is convicted of presenting to any federal agency a claim or making a statement that it knows to be false, fictitious or fraudulent. While the Company does not directly provide services to beneficiaries of federally funded health programs and, accordingly, does not directly submit claims to the federal government, it does provide services to federal government contractors, such as Part D Plans, and it is possible that the Company could nevertheless become involved in a situation where false claim issues are raised based on allegations that it caused or assisted a government contractor in making a false claim.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

The MMA that took effect on January 1, 2006, among other things, created a new voluntary outpatient prescription drug benefit for Medicare enrollees on an insured basis through PDPs, and by Medicare Advantage Plans, in various regions across the United States. Among other things, PDPs and Medicare Advantage Plans are subject to provisions of the MMA intended to deter fraud, waste and abuse and are monitored strictly by CMS and its contracted MEDICs to ensure that Part D program funds are not spent inappropriately. If CMS determines that the Company has not performed satisfactorily as a subcontractor, CMS may request a PDP or a Medicare Advantage Plan customer of the Company to revoke its Part D activities or responsibilities under the subcontract. The practices that are subject to regulation under these provisions are evolving and future applications or interpretations of these provisions could adversely affect the Company's operations.

FDA Regulation.

The FDA generally has authority to regulate drug promotional materials that are disseminated "by or on behalf of" a drug manufacturer. The Company's business includes the provision of educational seminars for prescribers and other of the Company's customers on behalf of manufacturer clients and thus is subject to the federal laws applicable to the promotion of prescription drugs.

State Anti-Remuneration/False Claims Laws.

Several states have laws and/or regulations similar to the federal anti-remuneration and Federal False Claims Act described above. Sanctions for violating these state anti-remuneration and false claims laws may include injunction, imprisonment, criminal and civil fines and exclusion from participation in the state Medicaid programs.

State Comprehensive PBM Regulation.

States continue to introduce broad legislation to regulate PBM activities. Some of this legislation would encompass the activities of the Company. In particular, such legislation seeks to impose fiduciary duties or disclosure obligations on entities that provide certain types of pharmacy management services. Both Maine and the District of Columbia have enacted statutes imposing fiduciary obligations on

entities providing pharmacy management services. Regulation of this nature could adversely affect the services the Company provides its customers.

State Legislation Affecting Plan Or Benefit Design.

Some states have enacted legislation that prohibits certain types of managed care plan sponsors from implementing certain restrictive formulary and network design features, and many states have legislation regulating various aspects of managed care plans, including provisions relating to the pharmacy benefits. Other states mandate coverage of certain benefits or conditions and require health plan coverage of specific drugs, if deemed medically necessary by the prescribing physician. Such legislation does not generally apply to the Company directly, but may apply to certain clients of the Company, such as HMOs and health insurers. If legislation of this nature were to become widely adopted and were applied to services the Company provides, it could have the effect of limiting the economic benefits achievable by the Company's customers through the use of the Company's services, adversely affecting the demand for the Company's services.

Legislation Affecting Drug Prices.

Under MMA, Part B drugs generally are reimbursed on an ASP methodology. This ASP methodology may create an incentive for some drug manufacturers to reduce the levels of discounts or rebates available to purchasers, including the Company, or their clients with respect to Medicare Part B drugs.

The federal Medicaid rebate statute provides that pharmaceutical manufacturers of brand-name outpatient prescription drugs must provide the Medicaid program a rebate in accordance with certain requirements. Investigations have been commenced by certain government agencies which question whether Medicaid rebates were properly calculated in accordance with such requirements, reported and paid by the manufacturers to the Medicaid programs. The Company is not responsible for such calculations, reports or payments. Some pharmaceutical manufacturers may view the Medicaid rebate statute and/or the associated investigations as a disincentive to offer rebates and discounts to private parties, including in the context of the Company's business.

Regulations Affecting the Company's Pharmacies.

The Company owns two mail order pharmacies that provide services to certain of the Company's health plan customers. The activities undertaken by the Company's pharmacies subject the pharmacies to state and federal statutes and regulations governing, among other things, the licensure and operation of mail order and non-resident pharmacies, repackaging of drug products, stocking of prescription drug products and dispensing of prescription drug products, including controlled substances. The Company's pharmacy facilities are located in Florida and New York and are duly licensed to conduct business in those states. Many states, however, require out-of-state mail order pharmacies to register with or be licensed by the state board of pharmacy or similar governing body when pharmaceuticals are delivered by mail into the state and some states require that an out-of-state pharmacy employ a pharmacist that is licensed in the state into which pharmaceuticals are shipped. Additional regulation of this nature may require the Company to expend additional funds to satisfy such regulatory requirements and could make it impractical for the Company to undertake certain business opportunities it may otherwise be interested in pursuing.

Regulation of Controlled Substances.

The Company's pharmacies must register with the DEA and individual state controlled substance authorities in order to dispense controlled substances. Federal law requires the Company to comply with the DEA's security, recordkeeping, inventory control, and labeling standards in order to dispense

controlled substances. State controlled substance law requires registration and compliance with state pharmacy licensure, registration or permit standards promulgated by the state pharmacy licensing authority.

Some of the state regulatory requirements described above may be preempted in whole or in part by ERISA, which provides for comprehensive federal regulation of employee benefit plans. However, the scope of ERISA preemption is uncertain and is subject to conflicting court rulings. As a result, the Company could be subject to overlapping federal and state regulatory requirements in respect of certain of its operations and may need to implement compliance programs that satisfy multiple regulatory regimes.

Other.

Most of the Company's distribution contracts with its customers use AWP as a benchmark for establishing pricing. As part of a proposed settlement in the case of New England Carpenters Health Benefit Fund, et. al. v. First Data Bank, et. al., Civil Action No. 1:05-CV-11148-PBS (D. Mass.), a case brought against First Data Bank, one of several companies that report data on prescription drug prices, First Data Bank has agreed to reduce the AWP of over 8,000 specific pharmaceutical products by four percent. The proposed settlement received preliminary but not final approval of the court, but at a fairness hearing on January 23, 2008, the court denied approval of the settlement without prejudice. The Company cannot predict whether or when the parties will attempt to cure any deficiencies identified by the court and resubmit the settlement for approval.

In the absence of any action on the part of the Company to renegotiate with its customers the pricing of those pharmaceutical distribution contracts that use AWP, a settlement that involves a reduction in First Data Bank's AWP could adversely affect the margin earned on those distribution contracts that use AWP, however it is not expected to have a material adverse affect on the Company's results of operations.

Risks Related To Realization of Goodwill and Intangible Assets The Company's profitability could be adversely affected if the value of intangible assets is not fully realized.

The Company's total assets at December 31, 2007 reflect goodwill of approximately $367.9 million, representing approximately 25.6 percent of total assets. The Company completed the Company's annual impairment analysis of goodwill as of October 1, 2007 noting that no impairment was identified.

At December 31, 2007, identifiable intangible assets (customer lists, contracts and provider networks) totaled approximately $59.2 million. Intangible assets are amortized over their estimated useful lives, which range from approximately three to ten years. The amortization periods used may differ from those used by other entities. In addition, the Company may be required to shorten the amortization period for intangible assets in future periods based on changes in the Company's business. There can be no assurance that such goodwill or intangible assets will be realizable.

The Company evaluates, on a regular basis, whether for any reason the carrying value of the Company's intangible assets and other long-lived assets may no longer be completely recoverable, in which case a charge to earnings for impairment losses could become necessary. When events or changes in circumstances occur that indicate the carrying amount of long-lived assets may not be recoverable, the Company assesses the recoverability of long-lived assets other than goodwill by determining whether the carrying value of such intangible assets will be recovered through the future cash flows expected from the use of the asset and its eventual disposition.

Any event or change in circumstances leading to a future determination requiring additional write-offs of a significant portion of unamortized intangible assets or goodwill would adversely affect the Company's profitability.

Risk of Potential Limitation of the Company's Net Operating Loss Carryforwards ("NOLs") Certain future changes in the composition of the Company's stockholder population could, in certain circumstances, limit the Company's ability to use the Company's NOLs.

The Company estimates that it has reportable federal NOLs as of December 31, 2007 of approximately $236.1 million available to reduce future federal taxable income. These estimated NOLs expire in 2011 through 2020 and are subject to examination and adjustment by the Internal Revenue Service ("IRS"). In addition, the Company's utilization of such NOLs is subject to limitation under Internal Revenue Code Section 382 ("Section 382"), which affects the timing of the use of these NOLs. At this time, the Company does not believe these limitations will limit the Company's ability to use any federal NOLs before they expire. Although the Company has NOLs that may be available to offset future taxable income, the Company may be subject to Federal Alternative Minimum Tax.

The limitations imposed by Section 382 provide that a corporation that undergoes an "ownership change" may generally thereafter only utilize its pre-change losses (including, in some cases, certain so-called "built-in" losses that have not yet been recognized for federal income tax purposes) to offset a fixed amount of taxable income per year. A corporation generally undergoes an ownership change if the percentage of stock of the corporation owned by one or more 5% shareholders has increased by more than 50 percentage points over, at most, a three-year period (with certain groups of less-than-5% shareholders treated as a single shareholder for this purpose).

In general, the amount of the annual limitation to which a corporation's pre-change losses are subject following an ownership change is equal to the product of (1) the fair market value of the corporation's stock immediately before the ownership change (subject to certain reductions) multiplied by (2) the "long-term tax-exempt rate" in effect for the month in which the ownership change occurs provided, however, that any existing Section 382 limitation cannot be increased due to a subsequent trigger of a Section 382 limitation. In certain circumstances, the annual limitation for a particular year may be increased due to the subsequent recognition of so-called "built-in" gains that existed at the time of the ownership change. Any unused limitation may be carried forward, thereby increasing the annual limitation in the subsequent taxable year. However, if the Company did not continue the Company's historic business or use a significant portion of the Company's assets in a new business for two years after the ownership change, the resulting annual limitation would be reduced, possibly to zero.

The Company underwent such an ownership change upon consummation of its reorganization in January 2004. A second ownership change likely occurred during December 2007, when the holdings of several investors each exceeded 5% for the first time. Subsequent changes in the Company's stock ownership, including sales of the Company's common stock by certain 5% shareholders, certain purchases that result in 5% or greater ownership of the Company's common stock, certain changes in the indirect beneficial ownership of the Company's common stock, and issuances or redemptions of common stock by the Company, could result in another ownership change that would trigger an additional Section 382 limitation.

The Company believes the Section 382 limitation resulting from the ownership change which likely occurred in 2007 is more favorable than the limitation from the 2004 ownership change. As such, the 2007 change is not expected to result in a deferral of the Company's ability to utilize its NOLs. However, the application of another Section 382 limitation on the Company's federal NOLs as a result of future ownership changes could reduce the amount of such NOLs the Company could utilize in a year, and thereby have an adverse effect on the Company's anticipated future cash flow, if, for example, the fair market value of the Company's stock were to decline significantly prior to such ownership change.

Claims for Professional Liability Pending or future actions or claims for professional liability (including any associated judgments, settlements, legal fees and other costs) could require the Company to make significant cash expenditures and consume significant management time and resources, which could have a material adverse effect on the Company's profitability and financial condition.

Management and administration of the delivery of specialty managed healthcare, the operation of specialty pharmacies and specialty pharmacy drug distribution, and the direct provision of healthcare treatment services such as the services that the Company provides through the direct care clinics operated under the Maricopa Contract, entail significant risks of liability. In recent years, participants in the healthcare industry generally, as well as the specialty managed healthcare industry, have become subject to an increasing number of lawsuits. From time to time, the Company is subject to various actions and claims of professional liability alleging negligence in performing utilization review and other specialty managed healthcare activities, as well as for the acts or omissions of the Company's employees, including employed physicians and other clinicians, network providers, pharmacists, or others. 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, the Company's employees, or the Company's network providers. The Company is also subject to actions and claims for the costs of services for which payment was denied. Many of these actions and claims seek substantial damages and require the Company to incur significant fees and costs related to the Company's defense and consume significant management time and resources. While the Company maintains professional liability insurance, there can be no assurance that future actions or claims for professional liability (including any judgments, settlements or costs associated therewith) will not have a material adverse effect on the Company's profitability and financial condition.

Professional Liability and Other Insurance Claims brought against the Company that exceed the scope of the Company's liability coverage or denial of coverage could materially and adversely affect the Company's profitability and financial condition.

The Company maintains a program of insurance coverage against a broad range of risks in the Company's business. As part of this program of insurance, the Company carries professional liability insurance, subject to certain deductibles and self-insured retentions. The Company also is sometimes required by customer contracts to post surety bonds with respect to the Company's potential liability on professional responsibility claims that may be asserted in connection with services the Company provides. As of December 31, 2007, the Company had approximately $52.4 million of such bonds outstanding. The Company's insurance may not be sufficient to cover any judgments, settlements or costs relating to present or future claims, suits or complaints. Upon expiration of the Company's insurance policies, sufficient insurance may not be available on favorable terms, if at all. To the extent the Company's customers are entitled to indemnification under their contracts with the Company relating to liabilities they incur arising from the operation of the Company's programs, such indemnification may not be covered under the Company's insurance policies. To the extent that certain actions and claims seek punitive and compensatory damages arising from the Company's alleged intentional misconduct, such damages, if awarded, may not be covered, in whole or in part, by the Company's insurance policies. The Company also has potential liability relating to the self-insurance program the Company maintained previously with respect to the Company's provider business. If the Company is unable to secure adequate insurance in the future, or if the insurance the Company carries is not sufficient to cover any judgments, settlements or costs relating to any present or future actions or claims, such judgments, settlements or costs may have a material adverse effect on the Company's profitability and financial condition. If the Company is unable to obtain needed surety bonds in adequate amounts or make alternative arrangements to satisfy the requirements for such bonds, the

Company may no longer be able to operate in those states, which would have a material adverse effect on the Company.

Class Action Suits and Other Legal Proceedings The Company is subject to class action and other lawsuits that could result in material liabilities to the Company or cause the Company to incur material costs, to change the Company's operating procedures in ways that increase costs or to comply with additional regulatory requirements.

Managed healthcare companies and PBM companies have been targeted as defendants in national class action lawsuits regarding their business practices. The Company has in the past been subject to such national class actions as defendants and is also subject to or a party to other class actions, lawsuits and legal proceedings in conducting the Company's business. In addition, certain of the Company's customers are parties to pending class action lawsuits regarding the customers' business practices for which the customers could seek indemnification from the Company. These lawsuits may take years to resolve and cause the Company to incur substantial litigation expenses and the outcomes could have a material adverse effect on the Company's profitability and financial condition. In addition to potential damage awards, depending upon the outcomes of such cases, these lawsuits may cause or force changes in practices of the Company's industry and may also cause additional regulation of the industry through new federal or state laws or new applications of existing laws or regulations. Such changes could increase the Company's operating costs.

Government Investigations The Company may be subjected to additional regulatory requirements and to investigations or regulatory action by governmental agencies, each of which may have a material adverse effect on the Company's business, financial condition and results of operations.

From time to time, the Company receives notifications from and engages in discussions with various government agencies concerning the Company's businesses and operations. As a result of these contacts with regulators, the Company may, as appropriate, be required to implement changes to the Company's operations, revise the Company's filings with such agencies and/or seek additional licenses to conduct the Company's business. The Company's inability to comply with the various regulatory requirements may have a material adverse effect on the Company's business.

In addition, the Company may become subject to regulatory investigations relating to the Company's business, which may result in litigation or regulatory action. A subsequent legal liability or a significant regulatory action against the Company could have a material adverse effect on the Company's business, financial condition and results of operations. Moreover, even if the Company ultimately prevails in the litigation, regulatory action or investigation, such litigation, regulatory action or investigation could have a material adverse effect on the Company's business, financial condition and results of operations.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

The Company currently leases approximately 1.7 million square feet of office space comprising 75 offices in 22 states and the District of Columbia, with terms expiring between January 2008 and January 2013. The Company's principal executive offices are located in Avon, Connecticut, which lease expires in September 2012. The Company believes that its current facilities are suitable for and adequate to support the level of its present operations.

Item 3. 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. See also "Risk Factors Claims for Professional Liability." 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. To date, claims and actions against the Company alleging professional negligence have not resulted in material liabilities and the Company does not believe that any such pending action against it will have a material adverse effect on the Company. However, there can be no assurance that pending or future actions or claims for professional liability (including any judgments, settlements or costs associated therewith) will not have a material adverse effect on the Company.

The Company is 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.

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

None.

PART II

Item 5. Market for Registrant's Common Equity and Related Stockholder Matters

Since January 6, 2004, shares of the Company's Ordinary Common Stock, $0.01 par value per share ("Ordinary Common Stock") have traded on the NASDAQ Stock Market under the symbol "MGLN." For further information regarding the Company's Ordinary Common Stock, see Note 7 "Stockholders' Equity" to the consolidated financial statements set forth elsewhere herein. Warrants to purchase shares of the Company's Ordinary Common Stock have traded on the Over-the-Counter Bulletin Board ("OTCBB") under the ticker symbol MGLNW since February 2, 2004. The following tables set forth the high and low closing bid prices of the Company's Ordinary Common Stock as reported by the NASDAQ Stock Market for the years ended December 31, 2006 and 2007, as follows:

	Ordinary Common Stock Sales Prices	
	High	Low
2006		
First Quarter	$ 40.63	$ 31.81
Second Quarter	45.55	37.87
Third Quarter	48.65	41.97
Fourth Quarter	45.08	40.08
2007		
First Quarter	$ 44.38	$ 40.14
Second Quarter	47.79	40.51
Third Quarter	47.11	38.29
Fourth Quarter	48.88	39.79

As of December 31, 2007, there were approximately 373 stockholders of record of the Ordinary Common Stock, and there were no outstanding shares of Multi-Vote Common Stock. The stockholders of record data for the Ordinary Common Stock does not reflect persons whose stock was held on that date by the Depository Trust Company or other intermediaries.

Comparison of Cumulative Total Returns

The following graph compares the change in the cumulative total return on the Company's common stock to (a) the change in the cumulative total return on the stocks included in the Standard & Poor's 500 Stock Index and (b) the change in the cumulative total return on the stocks included in the S&P 500 Managed Health Care Index, assuming an investment of $100 made at the close of trading on January 6, 2004, the first full day on which the common stock was registered under Section 12(g) of the Exchange Act and the first full day of trading on NASDAQ, and comparing relative values on December 31, 2004, 2005, 2006 and 2007. The common stock was first issued under the Company's plan of reorganization in connection with its bankruptcy proceedings on the Effective Date. The Company did not pay any dividends during the period reflected in the graph. Note that the common stock price performance shown below should not be viewed as being indicative of future performance.

Comparison of Cumulative Total Return

		December 31,			
	January 6, 2004	2004	2005	2006	2007
Magellan Health Services, Inc.	$ 100	$ 126.52	$ 116.48	$ 160.07	$ 172.70
S&P 500 Index	100	109.72	115.11	133.29	140.62
S&P 500 Managed Health Care Index(1)	100	155.63	222.08	207.47	239.75

(1) The S&P 500 Managed Health Care Index consists of Aetna, Inc., CIGNA Corp., Coventry Health Care, Inc., Humana, Inc., UnitedHealth Group, Inc. and WellPoint, Inc.

The information set forth above under the "Comparison of Cumulative Total Returns" does not constitute soliciting material and should not be deemed filed or incorporated by reference into any other of the Company's filings under the Securities Act of 1933 or the Securities Exchange Act of 1934, except to the extent the filing specifically incorporates such information by reference therein.

Dividends

The Company did not declare any dividends during either of the years ended December 31, 2006 or 2007. The Company is prohibited from paying dividends on the Ordinary Common Stock under the terms of the Credit Agreement, except in very limited circumstances. See "Management's Discussion and Analysis of Financial Condition and Results of Operations Outlook Liquidity and Capital Resources Restrictive Covenants in Debt Agreements."

Securities Authorized for Issuance Under Equity Compensation Plans

The following table sets forth certain information as of December 31, 2007 with respect to the Company's 2003 Management Incentive Plan ("2003 MIP") and 2006 Management Incentive Plan ("2006 MIP").

Plan category	Number of securities to be issued upon exercise of outstanding options, warrants and rights	Weighted average exercise price of outstanding options, warrants and rights	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column(a))
	(a)		
Equity compensation plans approved by security holders	3,813,285(1)	$ 36.79	884,975(2)
Equity compensation plans not approved by security holders			
Total	3,813,285(1)	$ 36.79	884,975(2)

(1) Excludes shares of restricted stock and restricted stock units purchased by employees or awarded to employees and the Company's directors pursuant to the 2003 MIP, the 2006 MIP, and the 2004 and 2005 Director Stock Compensation Plans. Additionally excludes 160,971 options issued to certain employees (mainly related to 100,000 options granted to employees that were previously employed by ICORE and 60,971 options granted to employees previously employed by NIA), and 84,840 options issued to certain of the Company's directors. For further discussion, see Note 7 "Stockholders' Equity" to the consolidated financial statements set forth elsewhere herein.

(2) Consists of shares remaining available for issuance as of December 31, 2007 under the 2003 MIP and 2006 MIP (under which the Company may issue stock options, restricted stock awards, stock bonuses, stock purchase rights and other equity incentives), after giving effect to the shares issuable upon the exercise of outstanding options, warrants and rights and the shares of restricted stock issued as referred to in footnote (1) above. Of the shares available for future grants under the terms of the 2003 MIP and 2006 MIP, 382,920 shares are reserved for future issuances of options. For further discussion, see Note 7 "Stockholders' Equity" to the consolidated financial statements set forth elsewhere herein.

Item 6. Selected Financial Data

The following table sets forth selected historical consolidated financial information of the Company as of and for the years ended December 31, 2003, 2004, 2005, 2006 and 2007.

In connection with the consummation of the Plan, the Company adopted the fresh start reporting provisions of American Institute of Certified Public Accountants ("AICPA") Statement of Position ("SOP") 90-7, "Financial Reporting by Entities in Reorganization Under the Bankruptcy Code" ("SOP 90-7") with respect to its financial reports, which required the Company to restate its assets and liabilities to their fair values based upon the provisions of the Plan and certain valuations which the Company made in connection with the implementation of the Plan. Under the provisions of SOP 90-7, fresh start reporting is not applied until all material conditions of the reorganization plan are satisfied. All material conditions to the Plan were satisfied as of December 29, 2003 (the "Material Conditions Date"). Due to the proximity of the Material Conditions Date to year end and the immateriality of the results of operations for the intervening two-day period through December 31, 2003, the Company applied fresh start reporting as if the material conditions were satisfied as of December 31, 2003. All adjustments and reorganization expenses as a result of the application of fresh start reporting are reflected in the consolidated financial statements as of and for the year ended December 31, 2003.

As a result of the application of the fresh start reporting provisions of SOP 90-7, all balance sheet data as of, and subsequent to December 31, 2003 represents balances of the "Reorganized Company." Statement of operations and statement of cash flows data for all periods prior to January 1, 2004 represents the results of the "Predecessor Company." Accordingly, all references to the Company with respect to disclosures of amounts recorded (i) through or prior to December 31, 2003 in relation to statement of operations or cash flow items, relate to the Predecessor Company. All references to the Company with respect to disclosures of amounts recorded or to be recorded (i) after December 31, 2003 in relation to statement of operations or cash flow items; and (ii) on or after December 31, 2003 in relation to balance sheet items, relate to the Reorganized Company.

As a result of the Company's financial restructuring under chapter 11 of the Bankruptcy Code commenced in March 2003 and consummated on the Effective Date, and the Company's implementation of fresh start reporting effective December 31, 2003, the selected statement of operations financial data for the year ended December 31, 2003 is not comparable to the subsequent periods presented. Selected financial data for the year ended December 31, 2003 includes the following significant unusual items:

Net reorganization benefit related to continuing operations of approximately $438.2 million, incurred in connection with the Company's financial restructuring. The reorganization benefit is primarily comprised of a net fresh start reorganization gain as a result of the application of fresh start reporting, a net benefit of approximately $7.5 million from lease rejections and court approved claim reductions, and interest income of approximately $1.1 million, which benefits were partially offset by expenses which include the write-off of deferred financing costs of approximately $18.5 million related to the Old Senior Notes and Old Subordinated Notes and approximately $31.6 million of professional fees incurred in conjunction with the financial restructuring activities and chapter 11 proceedings. The Company also recorded a net reorganization benefit related to discontinued operations of $20.3 million, inclusive of a $0.8 million tax benefit.

Pursuant to FIN 46, the Reorganized Company's balance sheets as of December 31, 2003, 2004, and 2005 included the assets and liabilities of the Premier joint venture, in which the Company owned a 50 percent interest; a variable interest entity ("VIE") for which the Company was the primary beneficiary. The creditors (or other beneficial interest holders) of Premier have no recourse to the general credit of the Company. The Reorganized Company adopted FIN 46 on December 31, 2003, as early adoption of new accounting pronouncements is required by

companies implementing the fresh start reporting provisions of SOP 90-7. The joint venture was accounted for under the equity method of accounting by the Company through December 31, 2003. On April 11, 2006, the Company purchased the other 50 percent interest in Premier for $1.5 million, so that Premier is now a wholly-owned subsidiary of the Company.

Effective as of December 31, 2005, the Company closed on the sale to Aetna of certain assets of the Company used in the management of behavioral healthcare services for Aetna's members (the "Aetna Assets"). The sale was concluded pursuant to the terms of a certain Asset Purchase Agreement dated February 23, 2005, as amended. The total consideration received by the Company was approximately $57.1 million, consisting of $30.0 million for the Aetna Assets and approximately $27.1 million for the delivery by the Company of executed addenda with Aetna to certain of the Company's network provider contracts (the "Network Amount"). At closing, Aetna paid the $30 million for the Aetna Assets and approximately $25.8 million of the Network Amount, with the remaining approximately $1.3 million of the Network Amount, which was subject to adjustment, to be paid 120 days after closing based upon the final calculation of the Network Amount. In connection with the closing, the Company paid approximately $50.2 million to Aetna in satisfaction of outstanding principal and interest on its previously issued promissory note to Aetna ("Aetna Notes"). The Company's contract with Aetna terminated on December 31, 2005.

Selected consolidated financial information for the years ended December 31, 2005, 2006 and 2007 and as of December 31, 2006 and 2007 presented below, have been derived from, and should be read in conjunction with, the consolidated financial statements and the notes thereto included elsewhere herein. Selected consolidated financial information for the years ended December 31, 2003 and 2004 has been derived from the Company's audited consolidated financial statements not included in this Form 10-K. The selected financial data set forth below also should be read in conjunction with "Management's Discussion and Analysis of Financial Condition and Results of Operations" appearing elsewhere herein.

MAGELLAN HEALTH SERVICES, INC. AND SUBSIDIARIES
(In thousands, except per share amounts)

	Predecessor Company	Reorganized Company			
	Year Ended December 31,	Year Ended December 31,			
	2003	2004	2005	2006	2007
Statement of Operations Data:					
Net revenue	$ 1,510,746	$ 1,795,402	$ 1,808,003	$ 1,690,270	$ 2,155,953
Cost of care	906,484	1,190,594	1,204,659	1,081,080	1,409,103
Cost of goods sold				41,809	149,585
Direct service costs and other operating expenses(1)	418,402	400,023	377,533	385,478	404,003
Equity in earnings of unconsolidated subsidiaries	(6,202)	(5,277)	(4,350)	(390)	
Depreciation and amortization	48,047	42,489	49,088	48,862	57,524
Interest expense (Contractual interest of $106,328 in fiscal 2003)	61,016	37,124	44,005	7,292	6,386
Interest income	(2,873)	(6,127)	(17,464)	(17,628)	(23,836)
Gain on sale of assets			(56,367)	(5,148)	
Reorganization benefit, net	(438,217)				
Goodwill impairment charges	28,780				
Special charges (benefits)	9,528	5,038	(556)		
Income from continuing operations before income taxes and minority interest	485,781	131,538	211,455	148,915	153,188
Provision for income taxes	33,813	64,835	82,405	62,695	58,669
Income from continuing operations before minority interest	451,968	66,703	129,050	86,220	94,519
Minority interest, net	253	347	58	(42)	361
Income from continuing operations	451,715	66,356	128,992	86,262	94,158
Income (loss) from discontinued operations(2)	(20,272)	(2,041)	1,597		
Reorganization benefit, net(2)	20,327				
Net income	451,770	64,315			