UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA

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UNITED STATES SECURITIES AND EXCHANGE COMMISSION,	:	
Plaintiff,	:	8:09-CV-00910-T-33EAJ
v.	:	**Civil Action No.** _____
WELLCARE HEALTH PLANS, INC.	:	
Defendant.	:	

COMPLAINT

Plaintiff, the United States Securities and Exchange Commission ("Commission"), alleges for its Complaint as follows:

SUMMARY

1. From at least November 2003 through at least October 2007 (the "relevant period"), defendant WellCare Health Plans, Inc. ("WellCare" or the "Company"), a managed health care services company, engaged in a fraudulent health care scheme which inflated its publicly reported profits by retaining over $40 million it was statutorily and contractually obligated to reimburse to agencies of the state of Florida. As a result, WellCare materially overstated its publicly reported net income and diluted earnings per share ("EPS") in its periodic filings with the Commission throughout this period.

2. WellCare, through the conduct of its officers and employees during the relevant period, executed its scheme by intentionally underpaying refunds it owed to two Florida state health care entities, the Florida Agency for Health Care Administration ("AHCA"), and the Florida Healthy Kids Corporation ("Healthy Kids"), as described below:

a. Under its contracts with AHCA, WellCare received funds, or "premiums" from the state to be used to provide medical and health benefits to qualified participants. A portion of those premiums were for outpatient mental health benefits. To ensure a proper balance between cost savings and quality health care, AHCA, pursuant to a statute adopted in 2002, Florida Statute § 409.912(4)(b) (the "80/20 Statute"), required WellCare to spend at least 80 percent of the outpatient mental health premiums on eligible medical expenses. If WellCare spent less than the minimum amounts on eligible expenses, it was required to refund the difference to AHCA. AHCA also established an annual reporting mechanism for WellCare and others subject to the statute to report their premiums, eligible medical expenses, and the refund, if any, due to AHCA.

b. Beginning in 2003, under its contracts with Healthy Kids, WellCare also received funds or premiums to be used to provide medical and health benefits to qualified participants. Under its contracts, WellCare was obligated to spend at least 85% of the premiums on eligible medical expenses. If WellCare spent less than the minimum amount on eligible expenses, it was required to refund 50% of the difference.

WellCare did not follow the guidelines and regulatory framework governing how the Company was required to calculate the refund under each of these programs. Instead, the Company fraudulently included ineligible payments to a subsidiary and administrative expenses in its refund calculations to reduce its reimbursement to the state. For certain refunds under the 80/20 Statute, WellCare considered a range of arbitrary amounts to refund to AHCA, and then reverse-engineered a methodology to arrive at a particular refund target. WellCare also engaged in a rate-swapping scheme whereby it inflated reimbursement rates for its Healthy Kids plan in exchange for lower Medicaid and Medicare rates with two Florida hospital groups. In total,

through its fraudulent conduct, WellCare reduced the refunds it paid to AHCA by approximately $35 million and to Healthy Kids by approximately $6 million. In connection with this scheme, WellCare made materially false and misleading statements and omissions in its public filings with the Commission.

3. Due to the practices described above, WellCare materially overstated its net income and EPS in its periodic filings with the Commission for its fiscal years ("FY") 2004 through 2006, including the quarterly periods within, and for the first quarter of FY 2007. The Company's financial statements during this period were not reported in conformity with Generally Accepted Accounting Principles ("GAAP"), because the Company improperly recognized revenue for premiums that it was not entitled to retain pursuant to statutory or contractual provisions.

4. WellCare failed to establish and maintain a system of internal accounting controls sufficient to prevent material misstatements in its books, records, accounts, and financial statements and to provide reasonable assurances that the Company's financial statements were prepared in conformity with GAAP. By engaging in the practices above, the Company thwarted any internal controls that did exist. Through its fraudulent actions, WellCare falsified its books, records, and accounts.

5. After the public became aware of a Government investigation into WellCare's conduct on October 24, 2007, the New York Stock Exchange halted trading in the Company's stock. On the following day, WellCare's stock price plummeted 63%. The Company's stock price, which traded at $115 before the news, is currently trading at approximately $18 a share.

6. During the course of the Commission's investigation of this matter, a Special

Committee of WellCare's Board of Directors conducted an internal investigation. In July 2008, based on the findings of the Special Committee, WellCare announced that it intended to restate its financial statements for FYs 2004 through 2006 and the first two quarters of FY 2007. On January 26, 2009, based on the findings of the Special Committee's investigation, WellCare filed its Form 10-K for FY 2007 and restated its financial results for its FYs 2004 through 2006 and the first two quarters of FY 2007 (the "Restatement"). The Restatement materially reduced WellCare's reported net income and EPS by essentially the same amounts - 14% for FY 2004, 9% for FY 2005, 13% for FY 2006, and 9% for the first quarter of FY 2007. In the Restatement, WellCare also acknowledged that there had been material weaknesses in its internal controls during the years at issue with respect to compliance with the regulatory requirements of the AHCA and Healthy Kids contracts, the Company's information and communication system, and the Company's financial reporting.

7. By engaging in the conduct described above, WellCare violated the antifraud, reporting, books and records, and internal controls provisions of the federal securities laws.

JURISDICTION AND VENUE

8. The Commission brings this action pursuant to Section 20(b) of the Securities Act of 1933 ("Securities Act") [15 U.S.C. § 77t(b)] and Section 21(d) of the Securities Exchange Act of 1934 ("Exchange Act") [15 U.S.C. § 78u(d)].

9. This Court has jurisdiction over this action pursuant to Section 22(a) of the Securities Act [15 U.S.C. § 77v(a)] and Sections 21(e) and 27 of the Exchange Act [15 U.S.C. §§ 78u(e) and 78aa]. The defendant, directly and indirectly, used the means or instrumentalities of transportation, interstate commerce, or of the mails, or the facilities of a national securities

exchange in connection with the transactions, acts, practices and course of business alleged in this Complaint.

10. Certain of the acts, practices and courses of conduct constituting the violations of law alleged in this Complaint occurred within this judicial district and, therefore, venue is proper pursuant to Section 22(a) of the Securities Act [15 U.S.C. § 77v(a)] and Section 27 of the Exchange Act [15 U.S.C. § 78aa]. WellCare, directly and indirectly, has engaged in, and unless restrained and enjoined by this Court will continue to engage in, transactions, acts, practices, and courses of business that violate Section 17(a) of the Securities Act [15 U.S.C. § 77q(a)], Sections 10(b), 13(a), 13(b)(2)(A) and 13(b)(2)(B) of the Exchange Act [15 U.S.C. §§ 78j(b), 78m(a), 78m(b)(2)(A) and 78m(b)(2)(B)] and Exchange Act Rules 10b-5, 12b-20, 13a-1, and 13a-13 [17 C.F.R. §§ 240.10b-5, 240.12b-20, 240.13a-1, and 240.13a-13].

DEFENDANT

11. WellCare is a Delaware corporation headquartered in Tampa, Florida. WellCare's common stock is registered with the Commission pursuant to Section 12(b) of the Exchange Act and trades on the New York Stock Exchange. At all times relevant to this Complaint, WellCare provided managed care services to government-sponsored healthcare programs, focusing on Medicaid and Medicare. The Company offered a variety of Medicaid and Medicare plans and, through subsidiaries, operated these plans in all 50 states. WellCare's fiscal year ends on December 31.

I. WELLCARE FRAUDULENTLY RETAINED HEALTH CARE PREMIUMS IT WAS REQUIREDTO REIMBURSE TO THE STATE OF FLORIDA.

A. WellCare Evaded the Requirements of Florida's 80/20 Statute.

12. At all times relevant to this Complaint, WellCare provided Medicaid services in the state of Florida through two health maintenance organizations ("HMOs"), StayWell Health Plan of Florida ("Staywell") and Healthease of Florida ("Healthease"). Staywell and Healthease, both wholly owned subsidiaries of WellCare, received funds from AHCA, the state agency which administered the Florida Medicaid program. Under WellCare's relevant contracts with AHCA, Staywell and Healthease were paid on a flat or "capitated" rate for each beneficiary or member enrolled in their respective health plans.

13. Government sponsored healthcare contracts in the state of Florida were crucial to WellCare's business. For example, in FY 2005, the state of Florida accounted for 48% of the Company's total premium revenues and almost 64% of its total membership. Between 2002 and 2006, WellCare received approximately $100 million in premiums from AHCA for the provision of behavioral health care services (also sometimes referred to as mental health services).

14. The 80/20 Statute mandated that all contracts issued for behavioral health care services through Medicaid require that 80% of all capitation funds paid to managed care plans, including HMOs, be spent on the provision of behavioral health care services. The 80/20 Statute further required that if any managed care plan spent less than 80% of the capitation payments it received from the state on behavioral health care services, it must refund the difference to AHCA. AHCA published two handbooks defining which services qualified as behavioral health care services. WellCare was aware, or should have been aware, of the 80/20 Statute and AHCA's definition of qualified services.

15. After the 80/20 Statute was implemented, Florida, through AHCA, provided premiums to WellCare's HMOs to spend on the outpatient behavioral health care services that were provided to its members. The statute required WellCare's HMOs to calculate the amount spent on behavioral health care services and, if the Company's HMOs spent less than 80% of the premiums it received from AHCA on such services, to refund the remainder. Stated in other terms, WellCare's HMOs were required to give money back to AHCA if their Medical Loss Ratios ("MLRs"), or these medical expenses divided by premium received, were below 80%.

16. If WellCare's HMOs had calculated their eligible health care expenses properly, the Company would have been required to make substantial refunds to the state under the 80/20 Statute. To avoid these refund liabilities, WellCare devised a scheme to cheat the state and AHCA and evade the requirements of the 80/20 Statute. On November 1, 2003, WellCare incorporated a subsidiary called Harmony Behavioral Health ("Harmony"), which purported to provide the full range of mental health and substance abuse services serving Medicaid, Medicare, and other members of WellCare's group of companies. WellCare's HMOs then assigned its contracts with "frontline" providers, e.g. physicians and other health care providers who provided the behavioral health services, to Harmony. Upon information and belief, WellCare formed Harmony, at least in part, for the purpose of reducing the refunds the company would have to pay the state under the 80/20 Statute.

17. Under the scheme, Harmony served as a conduit between WellCare's two HMOs, Staywell and Healthease, on the one hand, and the frontline providers, on the other. Harmony did not, in fact, provide behavioral health care services. AHCA paid premiums for behavioral health care services to Staywell and Healthease. The HMOs then passed a portion of those premiums on to Harmony, which in turn passed some of the premiums to the frontline providers.

At times, WellCare fraudulently included the total of the capitation payments it made to Harmony, rather than the ultimate payments to frontline providers, toward the provision of behavioral health care services for purposes of calculating the refund it owed the state under the 80/20 Statute.

18. After creating Harmony, WellCare established rates for the initial contracts between its two HMOs and Harmony by working backwards to determine what rates would be needed to ensure that the HMOs would pay Harmony 85% of the behavioral health premiums they received from AHCA, in order to reduce the likelihood of having to pay a refund to AHCA.

19. By improperly including payments to Harmony, as well as other ineligible expenses, in its refund calculations, WellCare was able to substantially reduce its annual refunds to AHCA under the 80/20 Statute. WellCare underpaid refunds to AHCA for four refund periods: the 2004 refund for part of calendar year 2002 and all of calendar year 2003; the 2005 refund for calendar year 2004; the 2006 refund for calendar year 2005; and the 2007 refund for calendar year 2006. Significantly, WellCare used a different strategy each year to calculate the amount it chose to refund to AHCA. Between 2004 and 2007, WellCare intentionally understated its refunds to AHCA by approximately $35 million.

1. WellCare Fraudulently Understated its 2004 Refund to AHCA for Calendar Years 2002 and 2003.

20. WellCare intentionally understated its 2004 refund to AHCA by approximately $6 million, or 50%. Because the refund related to expenses from 2002 and 2003, most of which pre-dated WellCare's creation of Harmony, the Company could only partially rely on capitation payments made from its two HMOs to Harmony as the basis for calculating the refund. Instead, WellCare understated its refund by deliberately including expenses that did not qualify as behavioral health care services, as defined by AHCA. WellCare calculated its refund by

improperly including capitation payments to Harmony, claims not included in AHCA's guidelines defining behavioral health care services, and administrative costs of one of WellCare's HMO offices. WellCare did not disclose to AHCA how it calculated the refund.

2. WellCare Fraudulently Understated its 2005 Refund to AHCA for Calendar Year 2004.

21. WellCare intentionally understated its 2005 refund to AHCA by approximately $8.9 million, or 90%. The Company calculated its 2004 refund of only $779,000 by improperly including the capitation amount paid to Harmony and subtracting that number from 80% of the AHCA premium. Again, WellCare disregarded AHCA's guidance regarding eligible behavioral health care expenses in calculating its refund. WellCare changed its means of calculating the refund for the purpose of meeting internally established refund goals and did not disclose to AHCA how it calculated the refund or that the manner of calculation differed from the previous year.

3. WellCare Fraudulently Understated its 2006 Refund to AHCA for Calendar Year 2005.

22. WellCare intentionally understated its 2006 refund to AHCA by approximately $6.7 million, or 80%. WellCare, which refunded only $1.4 million to AHCA in 2006, again changed its approach to calculating its refund in order to meet a predetermined internal goal. In fact, WellCare considered various scenarios in calculating its refund.to AHCA, which would have resulted in a refund ranging from zero to more than $11 million. WellCare ultimately calculated its 2005 refund to AHCA by improperly subtracting its payment to Harmony, plus certain fee-for-service costs, from the premium it received from AHCA. WellCare again failed to disclose to AHCA how it calculated the refund or that the manner of calculation differed from the previous year.

4. WellCare Fraudulently Understated its 2007 Refund to AHCA for Calendar Year 2006.

23. Of the approximately $37 million in premiums paid to WellCare by AHCA in 2006, WellCare refunded only $1.1 million. WellCare intentionally understated its 2007 refund to AHCA by approximately $13.5 million, or 90%. Again, WellCare considered various scenarios to calculate its refund in order to meet a predetermined internal refund goal, which the Company had set. WellCare derived its 2007 refund by taking the percentage of fee-for-service behavioral health expenses paid by Harmony to providers that fell within AHCA's eligible codes, which WellCare concluded was 85%, and applying that percentage to the capitation amount that its two HMOs paid to Harmony. WellCare then subtracted that amount from 80% of the premium WellCare received from AHCA. As WellCare knew, this calculation was deceptive, because a full 85% of every dollar the HMOs paid to Harmony was not used to provide behavioral health care services as defined by AHCA. WellCare again failed to disclose to AHCA how it calculated the refund or that the manner of calculation differed from the previous year.

5. WellCare Intentionally Misled AHCA in Response to Questions About its 2007 Refund for Calendar Year 2006.

24. A few days after WellCare submitted its 2007 refund in April 2007, AHCA pressed the Company for a detailed explanation of its refund calculation, including reimbursement amounts for each eligible behavioral health expense code. In response, WellCare submitted data to AHCA without detailed amounts for each code. AHCA informed WellCare that its submission included codes that were ineligible expenses and did not include amounts paid for each code. WellCare then resubmitted its data to AHCA, calculating the amounts so

that, in aggregate, they totaled an amount equal to or greater than the capitation paid to Harmony.

25. WellCare further misled AHCA by submitting false data in response to AHCA's January 2007 request for behavioral health "encounter" data, which WellCare defined as visits to fee-for-service providers or the number of visits paid for by WellCare pursuant to a capitated plan. WellCare concluded that if the Company submitted encounter prices based on the amounts paid by Harmony to frontline providers – which was significantly less than what WellCare had previously reported - AHCA would set rates based on those prices and future premiums would be reduced. To avoid this, WellCare arbitrarily decided to price encounters as equal to the capitation rates paid by WellCare's two HMOs to Harmony, which was 250% more than the actual amounts paid to providers. WellCare submitted this data to AHCA in February 2007 and falsely certified its accuracy.

26. In February 2007, AHCA made a follow-up request for behavioral health encounter data. In March 2007, WellCare submitted the encounter data to AHCA without any pricing information and falsely represented to AHCA that WellCare was not submitting the pricing information due to "system issues" and the limited time frame provided for submission. In truth, the Company omitted the pricing information in order to conceal the fact that its expenses were much lower than AHCA believed. WellCare again falsely certified the accuracy of the data submitted.

B. WellCare Fraudulently Manipulated Reimbursements Under the Florida Healthy Kids Program.

27. WellCare employed two different schemes in defrauding Healthy Kids, a federal and state-funded program that provides health insurance to uninsured children whose families are ineligible for Medicaid. First, using a strategy similar to its manipulation of the

80/20 Statute, the Company improperly calculated its reimbursements to Healthy Kids. Second, the Company inflated reimbursement rates under its Healthy Kids contracts in exchange for lower Medicaid and Medicare rates.

1. WellCare Fraudulently Understated Reimbursements to Healthy Kids for FYs 2004 through 2006.

28. WellCare defrauded Healthy Kids by understating reimbursements it owed to Healthy Kids under its contracts for 2004 through 2006 by nearly $5.9 million. Under the terms of its contract, if WellCare did not spend 85% of the premiums it received from Healthy Kids on eligible medical expenses, the Company was obligated to return one-half of the difference to Healthy Kids. WellCare manipulated this provision of the Healthy Kids contract by padding its medical expenses in order to understate its reimbursements to Healthy Kids. For example, WellCare improperly included administrative costs in its calculation of medical expenses under the contract.

29. In July 2005, WellCare provided misleading documentation to Healthy Kids to support its understated reimbursement amount. In this documentation, WellCare did not break out administrative expenses from medical expenses, even though WellCare identified these amounts separately in its internal communications. Thus, WellCare falsely represented to Healthy Kids that its total medical expenses were $54 million, while WellCare's internal documents made clear that the company's medical expenses were only $43 million, along with $11 million of administrative expenses. By improperly including administrative expenses in its reimbursement calculation, WellCare reduced its contract year 2004 payback to Healthy Kids from $5.6 million to only $333,000.

30. WellCare further understated its Healthy Kids reimbursements for contract years 2005 and 2006 by improperly incorporating in its reimbursement calculations capitation

payments made to Harmony that included an administrative component. WellCare thereby underpaid Healthy Kids by more than $250,000 for 2005 and 2006.

2. WellCare Exchanged Contract Rates in order to Defraud Healthy Kids.

31. In at least two instances, WellCare further defrauded Healthy Kids by improperly accepting higher reimbursement rates it paid to certain hospitals under its Healthy Kids contracts in exchange for lower Medicaid and Medicare rates. In 2005, WellCare entered negotiations with two large hospital networks in Florida regarding its Medicare, Medicaid, and Healthy Kids contracts. Generally, WellCare sought the lowest hospital reimbursement rates possible in its contracts with provider networks. In these two instances, however, WellCare agreed to pay higher reimbursement rates to the hospitals for its Healthy Kids contracts in exchange for paying lower rates for its Medicare and Medicaid contracts, without disclosure to Healthy Kids. WellCare intentionally traded these rates because each dollar of cost increase in WellCare's Medicare or Medicaid business would be borne entirely by WellCare, whereas each dollar increase under the Healthy Kids business would be borne 50% by Wellcare and 50% by Healthy Kids. WellCare's payment of higher Healthy Kids rates reduced the amount it had to refund to Healthy Kids and diverted profit to Medicare and Medicaid that otherwise would have been shared with Healthy Kids.

32. Further, WellCare requested rate increases from Healthy Kids to cover the increasing costs under that contract, even though it knew that a portion of the cost increases resulted solely from the Medicare and Medicaid rate trade. WellCare deliberately concealed its rate trading, which lowered its payments to Healthy Kids by approximately $700,000, from Healthy Kids.

II. WELLCARE FILED MATERIALLY FALSE AND MISLEADING PERIODIC REPORTS WITH THE COMMISSION.

A. Wellcare Materially Misstated its Financial Results for FYs 2004 through 2007.

33. By defrauding AHCA and Healthy Kids, WellCare materially misstated its financial results in its periodic reports with the Commission from FY 2004 through the first quarter of FY 2007. In addition, WellCare repeatedly made material misrepresentations and omissions in its filings with the Commission.

34. As set forth above, WellCare's financial statements throughout this period did not conform with GAAP, because the Company improperly recognized revenue for premiums that it was not entitled to retain pursuant to statutory or contractual provisions. Accounting Research Bulletin No. 43 states that "profit is deemed to be realized when a sale in the ordinary course of business is effected, unless the circumstances are such that the collection of the sales price is not reasonably assured." Additional guidance provided by Financial Accounting Standards Board Concepts Statement No. 5 and SEC Staff Accounting Bulletin No. 104 states that "revenues are considered to have been earned when the entity has substantially accomplished what it must do to be entitled to the benefits represented by the revenues."

35. In the Restatement, WellCare disclosed that it had overstated its net income by 14% in FY 2004, 9% in FY 2005, 13% in FY 2006, and 9% for the first quarter of FY 2007 and had overstated its EPS for these periods by essentially the same percentages. The Company restated its net income and EPS by these amounts.

36. In the Restatement, the Company admitted material weaknesses in its internal controls during the years at issue. WellCare failed to comply with the regulatory requirements of the AHCA and Healthy Kids contracts and failed to ensure effective communication between senior management, the Board of Directors, and state regulators. As a result of the Company's

failure to establish sufficient internal controls and its intentional thwarting of any existing internal controls, WellCare materially misstated its financial results from FY 2004 through the first quarter of FY 2007.

B. WellCare Made Materially False and Misleading Statements and Omissions in its Periodic Reports.

37. WellCare made numerous materially false and misleading statements and omissions in its periodic filings with the Commission during the relevant time. WellCare repeatedly attributed increases in premium revenue and net income to various business factors, such as increases in membership, premium rate increases, and maintaining a consistent ratio of medical benefits to costs. WellCare failed to disclose that its fraudulent retention of money that Florida had provided to it for health care expenditures artificially and materially boosted its reported revenue and earnings. In its periodic filings, WellCare also consistently disclosed the significance of its relationship to federal and state governments, including the consequences of violating the various statutes and rules applicable to its business. However, the Company never disclosed that it was jeopardizing its contracts with its largest customer, the state of Florida, by retaining funds it owed back to AHCA and Healthy Kids and providing information to the state that did not accurately reflect its business operations. Further, although WellCare disclosed that states sometimes required the Company to reimburse premiums received, WellCare never disclosed its refund obligations under the 80/20 Statute or the Healthy Kids contract or the amounts that WellCare refunded.

III. WELLCARE INCORPORATED MATERIALLY FALSE AND MISLEADING PERIODIC REPORTS IN SECURITIES REGISTRATION STATEMENTS FILED WITH THE COMMISSION.

38. During the relevant period, WellCare filed at least two registration statements with the Commission in which one or more materially false and misleading periodic reports were

incorporated by reference. The reports, among other things, materially overstated WellCare's revenue and net income and made false statements about the reasons for these increases.

39. The registration statements incorporating the materially false and misleading periodic reports included filings WellCare made to register stock for public offerings of 1.5 million shares in December 2004 and 500,000 shares in March 2006.

CLAIMS FOR RELIEF

FIRST CLAIM

Violations of Section 10(b) of the Exchange Act and Rule 10b-5 Thereunder (Fraud in Connection with the Purchase or Sale of Securities)

40. Paragraphs 1 through 39 above are realleged and incorporated herein by reference.

41. WellCare, directly or indirectly, by use of the means or instruments of interstate commerce, or of the mails, or of a facility of a national securities exchange, knowingly or recklessly, in connection with the purchase or sale of securities: (a) employed devices, schemes and artifices to defraud; (b) made untrue statements of a material fact or omitted to state a material fact, necessary in order to make the statements made, in light of the circumstances under which they were made, not misleading; or (c) engaged in acts, practices, and courses of business which operated or would operate as a fraud or deceit upon any person.

42. In connection with the above described fraudulent acts and omissions, WellCare acted knowingly or recklessly. Further, WellCare knew, or was reckless in not knowing, that the Company's periodic reports filed with the Commission were materially false and misleading.

43. By reason of the foregoing, WellCare violated Section 10(b) of the Exchange Act [15 U.S.C. § 78j(b)] and Exchange Act Rule 10b-5 [17 C.F.R. § 240.10b-5].

SECOND CLAIM

Violations of Section 17(a) of the Securities Act of 1933
(Fraud in the Offer or Sale of Securities)

44. Paragraphs 1 through 39 above are realleged and incorporated herein by reference.

45. WellCare, in the offer or sale of securities, by the use of the means or instruments of transportation or communication in interstate commerce or by the use of the mails, directly or indirectly: (a) employed devices, schemes, or artifices to defraud; (b) obtained money or property by means of untrue statements of material facts or omissions to state material facts necessary in order to make the statements made, in light of the circumstances under which they were made, not misleading; or (c) engaged in transactions, practices or courses of business which operated or would operate as a fraud or deceit upon purchasers of securities.

46. In connection with the above described acts and omissions, WellCare acted knowingly, recklessly, or negligently.

47. By reason of the foregoing, WellCare violated Section 17(a) of the Securities Act of 1933 [15 U.S.C. § 77q(a)].

THIRD CLAIM

Violations of Section 13(a) of the Exchange Act
and Exchange Act Rules 12b-20, 13a-1, and 13a-13
(Reporting Violations)

48. Paragraphs 1 through 39 above are realleged and incorporated herein by reference.

49. Section 13(a) of the Exchange Act [15 U.S.C. § 78m(a)] and Exchange Act Rules 13a-1 and 13a-13 [17 C.F.R. §§ 240.13a-1 and 240.13a-13] require issuers of registered securities to file with the Commission factually accurate annual and quarterly reports. Exchange

Act Rule 12b-20 [17 C.F.R. § 240.12b-20] provides that in addition to the information expressly required to be included in a statement or report, there shall be added such further material information, if any, as may be necessary to make the required statements, in the light of the circumstances under which they are made, not misleading.

50. As described above, WellCare filed with the Commission periodic reports, from FY 2004 through the second quarter of FY 2007, that were materially false and misleading or failed to include material information necessary to make the required statements in those reports, in light of the circumstances under which they were made, not misleading.

51. By reason of the foregoing, WellCare violated Section 13(a) of the Exchange Act [15 U.S.C. § 78m(a)] and Exchange Act Rules 12b-20, 13a-1, and 13a-13 [17 C.F.R. §§ 240.12b-20, 240.13a-1, and 240.13a-13].

FOURTH CLAIM

Violations of Sections 13(b)(2)(A) and 13(b)(2)(B) of the Exchange Act (Books and Records and Internal Control Violations)

52. Paragraphs 1 through 39 above are realleged and incorporated herein by reference.

53. Section 13(b)(2)(A) of the Exchange Act [15 U.S.C. § 78m(b)(2)(A)] requires public companies to make and keep books, records, and accounts which, in reasonable detail, accurately and fairly reflect the company's transactions and dispositions of its assets. Section 13(b)(2)(B) of the Exchange Act [15 U.S.C. § 78m(b)(2)(B)] requires public companies, among other things, to devise and maintain a system of internal accounting controls sufficient to provide reasonable assurances that the company's transactions were recorded as necessary to permit preparation of financial statements conforming with GAAP.

54. By reason of the foregoing, WellCare violated Sections 13(b)(2)(A) and 13(b)(2)(B) of the Exchange Act [15 U.S.C. §§ 78m(b)(2)(A) and 78m(b)(2)(B)].

PRAYER FOR RELIEF

WHEREFORE, The Commission respectfully requests that this Court enter a final judgment which:

I.

Permanently restrains and enjoins WellCare from further violations of Section 17(a) of the Securities Act [15 U.S.C. § 77q(a)], Sections 10(b), 13(a), 13(b)(2)(A) and 13(b)(2)(B) of the Exchange Act [15 U.S.C. §§ 78j(b), 78m(a), 78m(b)(2)(A) and 78m(b)(2)(B)] and Exchange Act Rules 10b-5, 12b-20, 13a-1, and 13a-13 [17 C.F.R. §§ 240.10b-5, 240.12b-20, 240.13a-1, and 240.13a-13];

II.

Orders WellCare to disgorge certain gains, together with prejudgment interest thereon;

III.

Orders WellCare to pay a civil penalty for its unlawful acts pursuant to Section 20(d) of the Securities Act [15 U.S.C. § 77t(d)] and Section 21(d)(3) of the Exchange Act [15 U.S.C. § 78u(d)(3)];

IV.

Retains jurisdiction of this action in accordance with the principles of equity and the Federal Rules of Civil Procedure in order to implement and carry out the terms of all orders and decrees that may be entered, or to entertain any suitable application or motion for additional relief within the jurisdiction of the Court; and

V.

Grants such other and further relief as this Court may deem necessary and appropriate under the circumstances.

Dated: May 18, 2009

Respectfully submitted,

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