CENTENE CORP
Form 10-Q
July 22, 2008

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

[X] QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the quarterly period ended June 30, 2008

OR

[ ] TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from to

Commission file number 001-31826

CENTENE CORPORATION
(Exact name of registrant as specified in its charter)

Delaware	42-1406317
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)
7711 Carondelet Avenue St. Louis, Missouri	63105

(Address of principal executive offices) (Zip Code)

Registrant's telephone number, including area code:

(314) 725-4477

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days: [X] Yes [ ] No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filed, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.
Large accelerated filer T Accelerated filer £ Non-accelerated filer £ Smaller reporting company £

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

As of July 14, 2008, the registrant had 43,233,059 shares of common stock outstanding.

CENTENE CORPORATION

QUARTERLY REPORT ON FORM 10-Q

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PART I

FINANCIAL INFORMATION

ITEM 1. Financial Statements.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS
(In thousands, except share data)

	June 30, 2008	December 31, 2007
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 357,488	$ 268,584
Premium and related receivables	113,233	90,072
Short-term investments, at fair value (amortized cost $69,205 and $46,392, respectively)	69,524	46,269
Other current assets	38,602	41,414
Total current assets	578,847	446,339
Long-term investments, at fair value (amortized cost $252,441 and $314,681, respectively)	254,578	317,041
Restricted deposits, at fair value (amortized cost $28,023 and $27,056, respectively)	28,283	27,301
Property, software and equipment, net	157,775	138,139
Goodwill	141,009	141,030
Other intangible assets, net	12,177	13,205
Other assets	42,396	36,067
Total assets	$ 1,215,065	$ 1,119,122
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liabilities	$ 363,708	$ 335,856
Accounts payable and accrued expenses	148,535	105,096
Unearned revenue	5,266	44,016
Current portion of long-term debt	338	971
Current liabilities of discontinued operations	200	861
Total current liabilities	518,047	486,800
Long-term debt	221,757	206,406
Other liabilities	15,493	10,869
Total liabilities	755,297	704,075
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; issued and outstanding 43,261,883 and 43,667,837 shares, respectively	43	44
Additional paid-in capital	222,438	221,693
Accumulated other comprehensive income:		
Unrealized gain on investments, net of tax	1,722	1,571
Retained earnings	235,565	191,739
Total stockholders' equity	459,768	415,047

Total liabilities and stockholders' equity	$ 1,215,065	$ 1,119,122

See notes to consolidated financial statements.

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CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS
(In thousands, except share data)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2008	2007	2008	2007
	(Unaudited)		(Unaudited)	
Revenues:				
Premium	$ 819,409	$ 687,842	$ 1,592,887	$ 1,312,668
Premium tax	22,192	19,874	44,823	37,690
Service	18,466	20,015	38,996	41,607
Total revenues	860,067	727,731	1,676,706	1,391,965
Expenses:				
Medical costs	682,589	575,146	1,324,208	1,103,666
Cost of services	14,437	16,670	30,613	32,300
General and administrative expenses	113,199	102,007	212,482	188,474
Premium tax	22,192	19,874	44,823	37,690
Total operating expenses	832,417	713,697	1,612,126	1,362,130
Earnings from operations	27,650	14,034	64,580	29,835
Other income (expense):				
Investment and other income	5,600	6,588	13,369	12,605
Interest expense	(4,065)	(4,213)	(8,059)	(7,345)
Earnings before income taxes	29,185	16,409	69,890	35,095
Income tax expense	11,146	6,234	26,314	13,323
Net earnings from continuing operations	18,039	10,175	43,576	21,772
Discontinued operations, net of income tax expense (benefit) of $101, $(5,417), $153 and $(32,197), respectively	164	7,607	250	34,221
Net earnings	$ 18,203	$ 17,782	$ 43,826	$ 55,993
Net earnings per share:				
Basic:				
Continuing operations	$ 0.42	$ 0.23	$ 1.00	$ 0.50
Discontinued operations	—	0.18	0.01	0.79
Basic earnings per common share	$ 0.42	$ 0.41	$ 1.01	$ 1.29
Diluted:				
Continuing operations	$ 0.41	$ 0.23	$ 0.98	$ 0.49
Discontinued operations	—	0.17	0.01	0.76
Diluted earnings per common share	$ 0.41	$ 0.40	$ 0.98	$ 1.25
Weighted average number of shares outstanding:				
Basic	43,375,944	43,617,360	43,457,076	43,525,848
Diluted	44,275,601	44,815,369	44,516,890	44,871,114

See notes to consolidated financial statements.

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CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)

	Six Months Ended June 30,	
	2008	2007
	(Unaudited)	
Cash flows from operating activities:		
Net earnings	$ 43,826	$ 55,993
Adjustments to reconcile net earnings to net cash provided by operating activities —		
Depreciation and amortization	16,229	12,991
Stock compensation expense	7,839	7,837
Deferred income taxes	11,879	(327)
Gain on sale of FirstGuard Missouri	—	(7,472)
Changes in assets and liabilities —		
Premium and related receivables	(23,144)	(21,823)
Other current assets	(4,294)	(24,583)
Other assets	(1,671)	(931)
Medical claims liabilities	27,316	15,035
Unearned revenue	(38,753)	8,203
Accounts payable and accrued expenses	45,907	11,832
Other operating activities	1,542	3,119
Net cash provided by operating activities	86,676	59,874
Cash flows from investing activities:		
Purchases of property, software and equipment	(34,581)	(29,352)
Purchases of investments	(172,873)	(290,962)
Sales and maturities of investments	210,277	196,407
Proceeds from asset sales	—	14,102
Investments in acquisitions and equity method investee, net of cash acquired	(7,818)	(5,336)
Net cash used in investing activities	(4,995)	(115,141)
Cash flows from financing activities:		
Proceeds from exercise of stock options	3,029	2,651
Proceeds from borrowings	56,005	191,000
Payment of long-term debt	(41,287)	(165,484)
Excess tax benefits from stock compensation	2,792	797
Common stock repurchases	(13,316)	(3,231)
Debt issue costs	—	(5,070)
Net cash provided by financing activities	7,223	20,663
Net increase (decrease) in cash and cash equivalents	88,904	(34,604)
Cash and cash equivalents, beginning of period	268,584	271,047
Cash and cash equivalents, end of period	$ 357,488	$ 236,443
Interest paid	$ 7,590	$ 3,738
Income taxes paid	$ 15,966	$ 6,049

See notes to consolidated financial statements.

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CENTENE CORPORATION AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Dollars in thousands, except share data)

1. Organization and Operations

Centene Corporation, or Centene or the Company, is a multi-line healthcare enterprise operating primarily in two segments: Medicaid Managed Care and Specialty Services. Centene's Medicaid Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government subsidized programs, including Medicaid, Medicare (Special Needs Plans), the State Children's Health Insurance Program, or SCHIP, Foster Care and Supplemental Security Income including Aged, Blind or Disabled programs, or SSI. The Company's Specialty Services segment provides specialty services, including behavioral health, life and health management, long-term care programs, managed vision, nurse triage, pharmacy benefits management and treatment compliance, to state programs, healthcare organizations, employer groups, and other commercial organizations, as well as to the Company's own subsidiaries on market-based terms.

2. Basis of Presentation

The unaudited interim financial statements herein have been prepared by the Company pursuant to the rules and regulations of the Securities and Exchange Commission. The accompanying interim financial statements have been prepared under the presumption that users of the interim financial information have either read or have access to the audited financial statements for the fiscal year ended December 31, 2007. Accordingly, footnote disclosures, which would substantially duplicate the disclosures contained in the December 31, 2007 audited financial statements, have been omitted from these interim financial statements where appropriate. In the opinion of management, these financial statements reflect all adjustments, consisting only of normal recurring adjustments, which are necessary for a fair presentation of the results of the interim periods presented.

Certain 2007 amounts in the consolidated financial statements have been reclassified to conform to the 2008 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

3. Recent Accounting Pronouncements

In December 2007, the Financial Accounting Standards Board, or FASB, issued Statement of Financial Accounting Standards No.141 (revised 2007), "Business Combinations", or SFAS No. 141R. The purpose of issuing the statement was to replace current guidance in SFAS No.141 to better represent the economic value of a business combination transaction. The changes to be effected with SFAS No. 141R from the current guidance include, but are not limited to: (1) acquisition costs will be recognized separately from the acquisition; (2) known contractual contingencies at the time of the acquisition will be considered part of the liabilities acquired and measured at their fair value; all other contingencies will be part of the liabilities acquired and measured at their fair value only if it is more likely than not that they meet the definition of a liability; (3) contingent consideration based on the outcome of future events will be recognized and measured at the time of the acquisition; (4) business combinations achieved in stages (step acquisitions) will need to recognize the identifiable assets and liabilities, as well as noncontrolling interests, in the acquiree, at the full amounts of their fair values; and (5) a bargain purchase (defined as a business combination in which the total acquisition-date fair value of the identifiable net assets acquired exceeds the fair value of the consideration transferred plus any noncontrolling interest in the acquiree) will require that excess to be recognized as a gain attributable to the acquirer. SFAS No. 141R will be effective for any business combinations that occur after January 1, 2009.

In December 2007, the FASB issued SFAS No. 160, “Noncontrolling Interests in Consolidated Financial Statements — an amendment of ARB No. 51”, or SFAS No. 160. SFAS No. 160 was issued to improve the relevance, comparability, and transparency of financial information provided to investors by requiring all entities to report noncontrolling (minority) interests in subsidiaries in the same way, that is, as equity in the consolidated financial statements. Moreover, SFAS No. 160 eliminates the diversity that currently exists in accounting for transactions between an entity and noncontrolling interests by requiring they be treated as equity transactions. SFAS No. 160 will be effective January 1, 2009. The Company is currently evaluating the impact that SFAS No. 160 will have on its financial statements and disclosures.

The Company adopted SFAS No. 157, “Fair Value Measurements” for financial assets and liabilities on January 1, 2008. Short-term investments, long-term investments and restricted deposits are classified as available for sale and are carried at fair value based on quoted market prices for identical securities (Level 1 inputs). Additionally, fair value of debt disclosures are based on quoted market prices of the Company’s debt securities or, for variable rate debt, fair value is considered equal to book value (Level 2 inputs).

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4. Discontinued Operations: FirstGuard Health Plans

In 2006, FirstGuard Health Plan Kansas, Inc., or FirstGuard Kansas, a wholly owned subsidiary, received notification that its Medicaid contract scheduled to terminate December 31, 2006 would not be renewed. In 2006, the Company also evaluated its strategic alternatives for its Missouri subsidiary, FirstGuard Health Plan, Inc., or FirstGuard Missouri, and decided to divest the business. FirstGuard Missouri was sold in February 2007. The assets, liabilities and results of operations of FirstGuard Kansas and FirstGuard Missouri are classified as discontinued operations for all periods presented beginning in December 2007, as substantially all liabilities had been paid as of that date.

5. Restructuring

In the fourth quarter of 2007, the Company abandoned its previously planned original redevelopment project in Clayton, Missouri, related to a corporate office expansion. As a result, the Company conducted an impairment analysis of the related real estate and capitalized construction costs and recorded an impairment charge of $7,207 at December 31, 2007. The impairment charges were recorded as General and Administrative expense under the Medicaid Managed Care segment. At June 30, 2008, the remaining liability for these charges was $850.

Also in the fourth quarter of 2007, the Company completed an organizational realignment, resulting in the elimination of approximately 35 positions. Accordingly, the Company recorded $2,185 in severance costs at December 31, 2007. This expense was recorded as General and Administrative expense under the Medicaid Managed Care segment. At June 30, 2008, the remaining liability for these costs was $153.

6. Debt

At June 30, 2008, total debt outstanding was $222,095, including current maturities of $338. The total debt outstanding consisted of $175,000 of senior notes due 2014, $20,364 of debt secured by real estate under the Company's $25,000 Revolving Loan Agreement discussed below, $20,000 under the Company's $300,000 Revolving Credit Agreement and $6,731 of capital leases. At June 30, 2008, the fair value of outstanding debt was approximately $212,033.

In February 2008, the Company refinanced its mortgage notes payable through the execution of an amendment to its $25,000 Revolving Loan Agreement. The amendment extends the maturity date to January 1, 2010 and borrowings under the agreement were amended to bear interest based upon LIBOR rates plus 1.0%.

7. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per common share:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2008	2007	2008	2007
Earnings:				
Earnings from continuing operations	$ 18,039	$ 10,175	$ 43,576	$ 21,772
Discontinued operations, net of tax	164	7,607	250	34,221
Net earnings	$ 18,203	$ 17,782	$ 43,826	$ 55,993
Shares used in computing per share amounts:				
Weighted average number of common shares outstanding	43,375,944	43,617,360	43,457,076	43,525,848
Common stock equivalents (as determined by applying the treasury stock method)	899,657	1,198,009	1,059,814	1,345,266

Weighted average number of common shares and potential dilutive common shares outstanding	44,275,601	44,815,369	44,516,890	44,871,114
Net earnings per share:				
Basic:				
Continued operations	$ 0.42	$ 0.23	$ 1.00	$ 0.50
Discontinued operations	—	0.18	0.01	0.79
Earnings per common share	$ 0.42	$ 0.41	$ 1.01	$ 1.29
Diluted:				
Continuing operations	$ 0.41	$ 0.23	$ 0.98	$ 0.49
Discontinued operations	—	0.17	0.01	0.76
Earnings per common share	$ 0.41	$ 0.40	$ 0.98	$ 1.25

The calculation of diluted earnings per common share for the three and six months ended June 30, 2008 excludes the impact of 3,127,400 and 2,824,000 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units. The calculation of diluted earnings per common share for the three and six months ended June 30, 2007 excludes the impact of 2,468,843 and 2,431,539 shares, respectively.

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8. Stockholders' Equity

In November 2005, the Company's board of directors adopted a stock repurchase program authorizing the Company to repurchase up to 4,000,000 shares of common stock from time to time on the open market or through privately negotiated transactions. In October 2007, the repurchase program was extended through October 31, 2008, but the Company reserves the right to suspend or discontinue the program at any time. During the six months ended June 30, 2008, the Company repurchased 697,764 shares at an average price of $19.08 and an aggregate cost of $13,316.

9. Contingencies

As previously disclosed, two class action lawsuits were filed against the Company and certain of its officers and directors in the United States District Court for the Eastern District of Missouri, or Eastern District Court. The lawsuits were consolidated on November 2, 2006 and an amended consolidated complaint was filed in the Eastern District Court on January 17, 2007, referred to as the Consolidated Lawsuit. The Consolidated Lawsuit alleges, on behalf of purchasers of the Company's common stock from April 25, 2006 through July 17, 2006, that the Company and certain of its officers and directors violated federal securities laws by issuing a series of materially false statements prior to the announcement of its fiscal 2006 second quarter results. According to the Consolidated Lawsuit, these allegedly materially false statements had the effect of artificially inflating the price of the Company's common stock, which subsequently dropped after the issuance of a press release announcing the Company's preliminary fiscal 2006 second quarter earnings and revised guidance. The Company filed a motion to dismiss the Consolidated Lawsuit. On June 29, 2007, the motion to dismiss was granted. The plaintiffs have appealed the order of dismissal, and briefing on the appeal has been completed. Oral argument on the appeal was held on April 18, 2008. A final judgment has not been rendered.

Additionally, in August 2006, a separate derivative action was filed on behalf of Centene Corporation against the Company and certain of its officers and directors in the Eastern District Court. Plaintiff purported to bring suit derivatively on behalf of the Company against the Company's directors for breach of fiduciary duties, gross mismanagement and waste of corporate assets by reason of the directors' alleged failure to correct the misstatements alleged in the Consolidated Lawsuit discussed above. The derivative complaint largely repeated the allegations in the Consolidated Lawsuit. Based on discussions that have been held with plaintiff's counsel, it is the Company's understanding that plaintiff did not intend to pursue this action unless the Consolidated Lawsuit proceeded past the dismissal stage. The derivative action has been dismissed.

The Company's subsidiary, Peach State Health Plan, received notice from the Georgia Department of Community Health, or GDCH, regarding the responsibility for payment of certain dual eligibility SSI claims. GDCH claims the Company is responsible for payment of health care claims for members while enrolled in the Georgia Families managed care program, including hospital stays that extend into the period where the member is covered by the State's separate SSI program. The Company clarified the issue with the state and recorded to Medical costs expense the estimated amount to settle the outstanding claims. This accrual is included in Medical claims liabilities at June 30, 2008.

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

10. Segment Information

The Company operates in two segments: Medicaid Managed Care and Specialty Services. The Medicaid Managed Care segment consists of the Company's health plans including all of the functions needed to operate them. The Specialty Services segment consists of the Company's specialty companies including behavioral health, health management, long-term care programs, managed vision, nurse triage, pharmacy benefits management and treatment compliance functions.

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

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Segment information for the three months ended June 30, 2008, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 789,144	$ 70,923	$ —	$ 860,067
Revenue from internal customers	15,718	125,545	(141,263)	—
Total revenue	$ 804,862	$ 196,468	$ (141,263)	$ 860,067
Earnings from operations	$ 22,800	$ 4,850	$ —	$ 27,650

Segment information for the three months ended June 30, 2007, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 665,258	$ 62,473	$ —	$ 727,731
Revenue from internal customers	19,698	106,783	(126,481)	—
Total revenue	$ 684,956	$ 169,256	$ (126,481)	$ 727,731
Earnings from operations	$ 9,073	$ 4,961	$ —	$ 14,034

Segment information for the six months ended June 30, 2008, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 1,535,234	$ 141,472	$ —	$ 1,676,706
Revenue from internal customers	31,104	235,825	(266,929)	—
Total revenue	$ 1,566,338	$ 377,297	$ (266,929)	$ 1,676,706
Earnings from operations	$ 52,602	$ 11,978	$ —	$ 64,580

Segment information for the six months ended June 30, 2007, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 1,271,720	$ 120,245	$ —	$ 1,391,965
Revenue from internal customers	38,586	205,502	(244,088)	—
Total revenue	$ 1,310,306	$ 325,747	$ (244,088)	$ 1,391,965
Earnings from operations	$ 19,188	$ 10,647	$ —	$ 29,835

11. Comprehensive Earnings

Differences between net earnings and total comprehensive earnings resulted from changes in unrealized losses and gains on investments available for sale, as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2008	2007	2008	2007

Net earnings	$ 18,203	$ 17,782	$ 43,826	$ 55,993
Reclassification adjustment, net of tax	126	18	151	69
Change in unrealized (loss) gain on investments, net of tax	(1,514)	(139)	—	136
Total comprehensive earnings	$ 16,815	$ 17,661	$ 43,977	$ 56,198

12. Subsequent Events

On July 1, 2008, the Company completed the previously announced acquisition of Celtic Insurance Company, or Celtic, a health insurance carrier focused on the individual health insurance market. The Company paid a total of $80,000 in cash plus additional transaction costs. The preliminary purchase price allocation will be determined during the third quarter of 2008. The results of operations of Celtic will be included in the Specialty Services segment of the consolidated financial statements beginning July 1, 2008. The Company received regulatory approval from the Illinois Division of Insurance to realize an extraordinary dividend of $31,411 from Celtic which was paid in July 2008.

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

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing, and in our annual report on Form 10-K for the year ended December 31, 2007. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under "Item 1A. Risk Factors."

OVERVIEW

We are a multi-line healthcare enterprise operating in two segments. Our Medicaid Managed Care segment provides Medicaid and Medicaid-related programs to organizations and individuals through government subsidized programs, including Medicaid, Medicare (Special Needs Plans), the State Children's Health Insurance Program, or SCHIP, Foster Care and Supplemental Security Income including Aged, Blind or Disabled programs, or SSI. Our Specialty Services segment provides specialty services, including behavioral health, life and health management, long-term care programs, managed vision, nurse triage, pharmacy benefits management and treatment compliance, to state programs, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries on market-based terms. Effective July 1, 2008, our Specialty Services segment also includes the individual health insurance market through our acquisition of Celtic Insurance Company, or Celtic.

Our Medicaid contract in Kansas terminated effective December 31, 2006, and we sold the operating assets of FirstGuard Health Plan, Inc., our Missouri health plan, effective February 1, 2007. Unless specifically noted, the discussions below are in the context of continuing operations, and therefore, exclude the Kansas and Missouri health plans, collectively referred to as FirstGuard. The results of operations for FirstGuard are classified as discontinued operations for all periods presented.

Our second quarter performance for 2008 is summarized as follows:

- Quarter-end Medicaid and Medicare Managed Care membership of 1,207,400.
- Total revenues of $860.1 million, an 18.2% increase over the comparable period in 2007.
- Health Benefits Ratio, or HBR, of 83.3%.
- General and Administrative, or G&A, expense ratio of 13.5%.
- Operating earnings of $27.7 million.
- Diluted earnings per share of $0.41.
- Operating cash flows of $60.0 million.

The following new contracts and acquisitions contributed to our growth during the last year:

~~In~~ April 2008, we began operating under our new contract in Texas to provide statewide managed care services to participants in the Texas Foster Care program, with 32,400 members at June 30, 2008.
~~In~~ 2007, we acquired PhyTrust of South Carolina, LLC, or PhyTrust, as well as Physician's Choice, LLC, both of which managed care on a non-risk basis for Medicaid members in South Carolina. We became licensed in 2007 to provide risk-based managed care in the State and began participating in the transition of the State's conversion to at-risk managed care in December 2007. We served 22,500 at-risk members in South Carolina at June 30, 2008.
~~In~~ July 2007, we acquired a 49% ownership interest in Access Health Solutions, LLC, or Access, which provides managed care for Medicaid recipients in Florida, with 97,000 members at June 30, 2008.

We have opportunities to increase profitability through the following:

—

Effective July 1, 2008, we completed the previously announced acquisition of Celtic, a health insurance carrier focused on the individual health insurance market.

Effective June 30, 2008, we concluded operations for SSI recipients in the Northwest region of Ohio. At June 30, 2008, this region represented 3,600 members.

During the second quarter of 2008, Bridgeway Health Solutions was awarded a contract with the Arizona Health Care Cost Containment System to provide Acute Care services to Medicaid recipients in the Yavapai service area. Membership operations are expected to commence on October 1, 2008.

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RESULTS OF OPERATIONS AND KEY METRICS

Summarized comparative financial data are as follows ($ in millions, except share data):

	Three Months Ended June 30,			Six Months Ended June 30,		
	2008	2007	% Change 2007-2008	2008	2007	% Change 2007-2008
Premium	$ 819.4	$ 687.8	19.1%	$ 1,592.9	$ 1,312.7	21.3%
Premium tax	22.2	19.9	11.7%	44.8	37.7	18.9%
Service	18.5	20.0	(7.7)%	39.0	41.6	(6.3)%
Total revenues	860.1	727.7	18.2%	1,676.7	1,392.0	20.5%
Medical costs	682.6	575.1	18.7%	1,324.2	1,103.7	20.0%
Cost of services	14.4	16.7	(13.4)%	30.6	32.3	(5.2)%
General and administrative expenses	113.2	102.0	11.0%	212.5	188.5	12.7%
Premium tax	22.2	19.9	11.7%	44.8	37.7	18.9%
Earnings from operations	27.7	14.0	97.0%	64.6	29.8	116.5%
Investment and other income, net	1.5	2.4	(35.4)%	5.3	5.3	1.0%
Earnings before income taxes	29.2	16.4	77.9%	69.9	35.1	99.1%
Income tax expense	11.2	6.2	78.8%	26.3	13.3	97.5%
Net earnings from continuing operations	18.0	10.2	77.3%	43.6	21.8	100.1%
Discontinued operations, net of income tax expense (benefit) of $0.1, $(5.4), $0.2 and $(32.2), respectively	0.2	7.6	(97.8)%	0.2	34.2	(99.3)%
Net earnings	$ 18.2	$ 17.8	2.4%	$ 43.8	$ 56.0	(21.7)%
Diluted earnings per share:						
Continuing operations	$ 0.41	$ 0.23	78.3%	$ 0.98	$ 0.49	100.0%
Discontinued operations	—	0.17	(100.0)%	0.01	0.76	(98.7)%
Total diluted earnings per common share	$ 0.41	$ 0.40	2.5 %	$ 0.98	$ 1.25	(21.6)%

Revenues and Revenue Recognition

Our Medicaid Managed Care segment generates revenues primarily from premiums we receive from the states in which we operate health plans. We receive a fixed premium per member per month pursuant to our state contracts. We generally receive premium payments during the month we provide services and recognize premium

revenue during the period in which we are obligated to provide services to our members. Some states enact premium taxes or similar assessments, collectively, premium taxes, and these taxes are recorded as a component of revenue as well as operating expenses. Some contracts allow for additional premium associated with certain supplemental services provided such as maternity deliveries. Revenues are recorded based on membership and eligibility data provided by the states, which may be adjusted by the states for updates to this data. These adjustments have been immaterial in relation to total revenue recorded and are reflected in the period known.

Our Specialty Services segment generates revenues under contracts with state programs, healthcare organizations, and other commercial organizations, as well as from our own subsidiaries on market-based terms. Revenues are recognized when the related services are provided or as ratably earned over the covered period of services.

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

Our total revenue increased in the three and six months ended June 30, 2008 over the previous year primarily through 1) membership growth in the Medicaid Managed Care segment, 2) premium rate increases, and 3) growth in our Specialty Services segment.

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1. Membership growth

From June 30, 2007 to June 30, 2008, we increased our Medicaid Managed Care membership by 6.7%. The following table sets forth our membership by state in our Medicaid Managed Care segment:

	June 30,	
	2008	2007
Georgia	278,800	281,400
Indiana	161,700	161,700
New Jersey	55,100	59,100
Ohio	137,300	128,200
South Carolina	22,500	31,100
Texas	427,200	333,900
Wisconsin	124,800	136,100
Total	1,207,400	1,131,500

The following table sets forth our membership by line of business in our Medicaid Managed Care segment:

	June 30,	
	2008	2007
Medicaid	866,700	846,900
SCHIP/Foster Care	267,000	216,500
SSI/Medicare	73,700	68,100
Total	1,207,400	1,131,500

From June 30, 2007 to June 30, 2008, our membership increased as a result of growth in Ohio and Texas. We increased our SSI membership in Ohio with the commencement of our new contract to serve Aged, Blind or Disabled members. In Texas, we increased our membership through organic growth of SCHIP, especially in the EPO market. In addition, we increased Texas membership through our new Foster Care program, with 32,400 members at June 30, 2008. Our membership decreased in Wisconsin due to the termination of certain physician contracts associated with a high cost hospital system and medical group. In South Carolina, we continue to add at-risk membership as additional counties convert, with 22,500 at-risk members at June 30, 2008. The prior year membership in South Carolina was entirely on a non-risk basis. In Florida, Access served 97,000 members on a non-risk basis at June 30, 2008.

2. Premium rate increases

During the six months ended June 30, 2008, we received premium rate increases in some markets which yield a 2.1% composite increase across all of our markets. During the six months ended June 30, 2007, we received premium rate increases in some markets which yield a 2.1% composite increase across all of our markets.

In November 2007, we received a contract amendment from the State of Georgia providing for an effective premium rate increase in Georgia of approximately 3.8% effective July 1, 2007. The State also mandated service changes, retroactively recalculated certain rate cells and adjusted for duplicate member issues. We executed this amendment on November 16, 2007. The State of Georgia returned the fully executed contract in January 2008 and, accordingly, we recorded the additional premium revenue, retroactive to July 1, 2007, in the first quarter of 2008. This premium revenue, related to the period from July 1, 2007 to December 31, 2007, totals approximately $20.8 million.

Approximately $7.3 million of this amount is related to the mandated services, rate cell changes and duplicate member issues, the remaining $13.5 million yields the calculated 3.8% increase.

3. Specialty Services segment growth

For the three and six months ended June 30, 2008, Specialty Services segment revenue from external customers was $70.9 million and $141.5 million, respectively, compared to $62.5 million and $120.2 million for the same prior year periods. The increase is primarily attributable to increasing membership for both our behavioral health company, Cenpatico, and our long-term care program, Bridgeway. At June 30, 2008, Cenpatico provided behavioral health services to 99,400 members in Arizona and 40,000 members in Kansas, compared to 95,200 members in Arizona and 37,500 members in Kansas at June 30, 2007. At June 30, 2008, Bridgeway provided long-term care services to 1,800 members, compared to 1,300 members at June 30, 2007.

Medical Costs

Our medical costs include payments to physicians, hospitals, and other providers for healthcare and specialty services claims. Medical costs also include estimates of medical expenses incurred but not yet reported, or IBNR, and estimates of the cost to process unpaid claims. Monthly, we estimate our IBNR based on a number of factors, including inpatient hospital utilization data and prior claims experience. As part of this review, we also consider the costs to process medical claims and estimates of amounts to cover uncertainties associated with fluctuations in physician billing patterns, membership, products and inpatient hospital trends. These estimates are adjusted as more information becomes available. We employ actuarial professionals and use the services of independent actuaries who are contracted to review our estimates quarterly. While we believe that our process for estimating IBNR is actuarially sound, we cannot assure you that healthcare claim costs will not materially differ from our estimates.

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Our results of operations depend on our ability to manage expenses associated with health benefits and to accurately predict costs incurred. Our health benefits ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding premium taxes) and reflects the direct relationship between the premium received and the medical services provided. The table below depicts our HBR for our external membership by member category:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2008	2007	2008	2007
Medicaid and SCHIP	81.7%	83.2%	80.6%	83.9%
SSI and Medicare	89.8	90.2	93.7	89.6
Specialty Services	85.8	76.4	85.0	77.9
Total	83.3	83.6	83.1	84.1

Our consolidated HBR for the three and six months ended June 30, 2008 were 83.3% and 83.1%, respectively, decreases of 0.3% and 1.0% over 2007. The decrease for the second quarter of 2008 over 2007 is due to overall increased premium yield. The decrease for the six months ended June 30, 2008 over 2007 is due to the aforementioned factor as well as the effect of recording the Georgia premium rate increase retroactive to July 1, 2007. Sequentially, our consolidated HBR increased from 83.0% in the 2008 first quarter to 83.3% due to the effect of the Georgia rate increase, offset by moderating medical cost trends, especially related to SSI members in Ohio. The additional Georgia premium revenue of $20.8 million recorded in the first quarter of 2008 had the effect of decreasing our first quarter consolidated HBR by 2.2%.

Cost of Services

Our cost of services expense includes the pharmaceutical costs associated with our pharmacy benefit manager's external revenues. Cost of services also includes all direct costs to support the functions responsible for generation of our services revenues. These expenses consist of the salaries and wages of the teachers and other professionals who provide the services and expenses associated with facilities and equipment used to provide services.

General and Administrative Expenses

Our general and administrative expenses, or G&A, primarily reflect wages and benefits, including stock compensation expense, and other administrative costs associated with our health plans, specialty companies and centralized functions that support all of our business units. Our major centralized functions are finance, information systems and claims processing. G&A increased in the three and six months ended June 30, 2008 over the comparable period in 2007 primarily due to expenses for additional facilities and staff to support our growth.

Our G&A expense ratio represents G&A expenses as a percentage of the sum of Premium revenue and Service revenue, and reflects the relationship between revenues earned and the costs necessary to earn those revenues. The consolidated G&A expense ratio for the three and six months ended June 30, 2008 were 13.5% and 13.0%, respectively, compared to 14.4% and 13.9% for the same periods in 2007. The ratio continues to reflect the overall leveraging of our expenses over higher revenues, partially offset by the effect of our start-up costs in Florida, South Carolina and for our Texas Foster Care product.

Other Income (Expense)

Other income (expense) consists principally of investment income from our cash and investments, our equity in earnings of Access, and interest expense on our debt. Investment and other income decreased $1.0 million and increased $0.8 million in the three and six months ended June 30, 2008, respectively, over the comparable period in 2007. The decrease in the second quarter was primarily due to an overall decline in investment interest rates. The increase for the six months was due to increased equity in earnings of unconsolidated subsidiaries resulting from our investment in Access, partially offset by an overall decline in investment interest rates. Realized gains on the sale of investments were $201 thousand for the six months ended June 30, 2008 compared to realized losses of $47 thousand for the six months ended June 30, 2007.

Income Tax Expense

Our effective tax rates for the three and six months ended June 30, 2008 were 38.2% and 37.7%, respectively, compared to 38.0% for both the three and six months ended June 30, 2007.

Discontinued Operations

Net earnings from discontinued operations were $164 thousand and $250 thousand in the three and six months ended June 30, 2008, respectively compared to net earnings of $7.6 million and $34.2 million in the three and six months ended June 30, 2007, respectively. In the first half of 2007, we abandoned the stock of our FirstGuard health plans resulting in tax benefits of $34.0 million, net of the associated asset write-offs. The 2007 results also included exit costs associated with FirstGuard and one month of FirstGuard Missouri operations. ––––––––––––

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LIQUIDITY AND CAPITAL RESOURCES

We finance our activities primarily through operating cash flows and borrowings under our revolving credit facility. Our total operating activities provided cash of $86.7 million in the six months ended June 30, 2008 compared to $59.9 million in the comparable period in 2007. The increase was primarily due to a change in our cash management procedure whereby negative book cash balances resulting from checks issued but not yet presented to our bank for payment are now included in Accounts payable and accrued expenses. Additonally, consistent with prior years, both periods reflect an increase in premium and related receivables related to the June capitation payment from the State of Wisconsin. The State holds this payment over their fiscal year-end and it was received in July along with the July capitation payment in both years.

Our investing activities used cash of $5.0 million in the six months ended June 30, 2008 compared to $115.1 million in the comparable period in 2007. Net cash provided by and used in investing activities will fluctuate from year to year due to the timing of investment purchases, sales and maturities. Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets within our investment guidelines. As of June 30, 2008, our investment portfolio consisted primarily of fixed-income securities with an average duration of 1.6 years. Cash is invested in investment vehicles such as municipal bonds, corporate bonds, instruments of the U.S. Treasury, insurance contracts, commercial paper and equity securities. These securities generally are actively traded in secondary markets and the reported fair market value is determined based on recent trading activity. The states in which we operate prescribe the types of instruments in which our regulated subsidiaries may invest their cash.

We spent $34.6 million and $29.4 million in the six months ended June 30, 2008 and 2007, respectively, on capital assets consisting primarily of property, software and hardware upgrades, furniture, equipment, and leasehold improvements associated with office and market expansions. We anticipate spending approximately an additional $38 million on capital expenditures in 2008 primarily associated with system enhancements and market expansions.

Our financing activities provided cash of $7.2 million and $20.7 million in the six months ended June 30, 2008 and 2007, respectively. During 2008, our financing activities primarily related to proceeds from borrowings under our $300 million credit facility and stock repurchases. During 2007, our financing activities primarily related to proceeds from issuance of $175 million in senior notes.

At June 30, 2008, we had working capital, defined as current assets less current liabilities, of $60.8 million, as compared to $(40.5) million at December 31, 2007. Our working capital was negative at December 31, 2007 due to our efforts to increase investment returns through purchases of investments that have maturities of greater than one year and, therefore, were classified as long-term. We manage our short-term and long-term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short-term requirements as needed.

Cash, cash equivalents and short-term investments were $427.0 million at June 30, 2008 and $314.9 million at December 31, 2007. Long-term investments were $282.9 million at June 30, 2008 and $344.3 million at December 31, 2007, including restricted deposits of $28.3 million and $27.3 million, respectively. At June 30, 2008, cash and investments held by our unregulated entities totaled $29.0 million while cash and investments held by our regulated entities totaled $680.9 million.

We have a $300 million Revolving Credit Agreement. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. There is a commitment fee on the unused portion of the agreement that ranges from 0.15% to 0.275% depending on the total debt to EBITDA ratio. The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt to EBITDA ratios and minimum net worth. The agreement will expire in September 2011. As of June 30, 2008,

we had $20.0 million in borrowings outstanding under the agreement and $23.6 million in letters of credit outstanding, leaving availability of $256.4 million. As of June 30, 2008, we were in compliance with all covenants.

On July 1, 2008 we completed the acquisition of Celtic for a purchase price of $80.0 million plus additional transaction costs. Concurrent with the acquisition, we received regulatory approval to pay a dividend from Celtic to Centene in an amount of $31.4 million, while still maintaining a capital structure we believe to be conservative. As a result of the dividend, the net effect on our unregulated cash was approximately $50 million.

We have a shelf registration statement on Form S-3 on file with the Securities and Exchange Commission, or the SEC, covering the issuance of up to $300 million of securities including common stock and debt securities. No securities have been issued under the shelf registration. We may publicly offer securities from time-to-time at prices and terms to be determined at the time of the offering.

We have a stock repurchase program authorizing us to repurchase up to four million shares of common stock from time to time on the open market or through privately negotiated transactions. In October 2007, the repurchase program was extended through October 31, 2008, but we reserve the right to suspend or discontinue the program at any time. During the six months ended June 30, 2008, we repurchased 697,764 at an average price of $19.08. We have established a trading plan with a registered broker to repurchase shares under certain market conditions.
There were no other material changes outside the ordinary course of business in lease obligations or other contractual obligations in the six months ended June 30, 2008. Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our credit facility will be sufficient to finance our operations, planned acquisition of Celtic Insurance Company and capital expenditures for at least 12 months from the date of this filing.

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REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

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

Our regulated subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of June 30, 2008, our subsidiaries had aggregate statutory capital and surplus of $341.0 million, compared with the required minimum aggregate statutory capital and surplus requirements of $207.5 million.

The National Association of Insurance Commissioners has adopted rules which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of June 30, 2008, all of our health plans were in compliance with the risk-based capital requirements enacted in their respective states.

RECENT ACCOUNTING PRONOUNCEMENTS

In December 2007, the Financial Accounting Standards Board, or FASB, issued Statement of Financial Accounting standards No.141 (revised 2007), "Business Combinations", or SFAS No. 141R. The purpose of issuing the statement was to replace current guidance in SFAS No.141 to better represent the economic value of a business combination transaction. The changes to be effected with SFAS No. 141R from the current guidance include, but are not limited to: (1) acquisition costs will be recognized separately from the acquisition; (2) known contractual contingencies at the time of the acquisition will be considered part of the liabilities acquired and and measured at their fair value; all other contingencies will be part of the liabilities acquired and measured at their fair value only if it is more likely than not that they meet the definition of a liability; (3) contingent consideration based on the outcome of future events will be recognized and measured at the time of the acquisition; (4) business combinations achieved in stages (step acquisitions) will need to recognize the identifiable assets and liabilities, as well as noncontrolling interests, in the acquiree, at the full amounts of their fair values; and (5) a bargain purchase (defined as a business combination in which the total acquisition-date fair value of the identifiable net assets acquired exceeds the fair value of the consideration transferred plus any noncontrolling interest in the acquiree) will require that excess to be recognized as a gain attributable to the acquirer. SFAS No. 141R will be effective for any business combinations that occur after January 1, 2009.

In December 2007, the FASB issued SFAS No. 160, "Noncontrolling Interests in Consolidated Financial Statements — an amendment of ARB No. 51", or SFAS No. 160. SFAS No. 160 was issued to improve the relevance, comparability, and transparency of financial information provided to investors by requiring all entities to report noncontrolling (minority) interests in subsidiaries in the same way, that is, as equity in the consolidated financial statements. Moreover, SFAS No. 160 eliminates the diversity that currently exists in accounting for transactions between an entity and noncontrolling interests by requiring they be treated as equity transactions. SFAS No. 160 will be effective January 1, 2009. We are currently evaluating the impact that SFAS No. 160 will have on our financial statements and disclosures.

We adopted SFAS No. 157, "Fair Value Measurements" for financial assets and liabilities on January 1, 2008. Short-term investments, long-term investments and restricted deposits are classified as available for sale and are carried at fair value based on quoted market prices for identical securities (Level 1 inputs). Additionally, fair

value of debt disclosures are based on quoted market prices of the Company's debt securities or, for variable rate debt, fair value is considered equal to book value (Level 2 inputs).

FORWARD-LOOKING STATEMENTS

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

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All forward-looking statements included in this filing are based on information available to us on the date of this filing. Actual results may differ from projections or estimates due to a variety of important factors, including:

- our ability to accurately predict and effectively manage health benefits and other operating expenses;
- competition;
- changes in healthcare practices;
- changes in federal or state laws or regulations;
- inflation;
- provider contract changes;
- new technologies;
- reduction in provider payments by governmental payors;
- major epidemics;
- disasters and numerous other factors affecting the delivery and cost of healthcare;
- the expiration, cancellation or suspension of our Medicaid managed care contracts by state governments;
- availability of debt and equity financing, on terms that are favorable to us; and
- general economic and market conditions.

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

ITEM 3. Quantitative and Qualitative Disclosures About Market Risk.

INVESTMENTS

As of June 30, 2008, we had short-term investments of $69.5 million and long-term investments of $282.9 million, including restricted deposits of $28.3 million. The short-term investments consist of highly liquid securities with maturities between three and 12 months. The long-term investments consist of municipal, corporate and U.S. Agency bonds, life insurance contracts, U.S. Treasury investments and equity securities and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long-term regardless of the contractual maturity date. Our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at June 30, 2008, the fair value of our fixed income investments would decrease by approximately $4.6 million. Declines in interest rates over time will reduce our investment income.

INFLATION

Although healthcare cost inflation has stabilized in recent years, the national healthcare cost inflation rate still exceeds the general inflation rate. Additionally, recent economic indicators suggest an accelerated rise of the general inflation rate. We use various strategies to mitigate the negative effects of healthcare cost inflation. Specifically, our health plans try to control medical and hospital costs through our margin protection program and contracts with independent providers of healthcare services. Through these contracted care providers, our health plans emphasize preventive healthcare and appropriate use of specialty and hospital services.

While we currently believe our strategies to mitigate healthcare cost inflation will continue to be successful, competitive pressures, new healthcare and pharmaceutical product introductions, demands from healthcare providers

and customers, applicable regulations or other factors may affect our ability to control the impact of healthcare cost increases.

ITEM 4. Controls and Procedures.

Evaluation of Disclosure Controls and Procedures - Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, evaluated the effectiveness of our disclosure controls and procedures as of June 30, 2008. The term “disclosure controls and procedures,” as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act, means controls and other procedures of a company that are designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the company’s management, including its principal executive and principal financial officers, as appropriate to allow timely decisions regarding required disclosure. Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving their objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Based on the evaluation of our disclosure controls and procedures as of June 30, 2008, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective at the reasonable assurance level.

Changes in Internal Control Over Financial Reporting - No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the quarter ended June 30, 2008 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

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PART II

OTHER INFORMATION

ITEM 1. Legal Proceedings.

As previously disclosed, two class action lawsuits were filed against us and certain of our officers and directors in the United States District Court for the Eastern District of Missouri, or Eastern District Court. The lawsuits were consolidated on November 2, 2006, and an amended consolidated complaint was filed in the Eastern District Court on January 17, 2007, which we refer to as the Consolidated Lawsuit. The Consolidated Lawsuit alleges, on behalf of purchasers of our common stock from April 25, 2006 through July 17, 2006, that we and certain of our officers and directors violated federal securities laws by issuing a series of materially false statements prior to the announcement of our fiscal 2006 second quarter results. According to the Consolidated Lawsuit, these allegedly materially false statements had the effect of artificially inflating the price of our common stock, which subsequently dropped after the issuance of a press release announcing our preliminary fiscal 2006 second quarter earnings and revised guidance. We filed a motion to dismiss the Consolidated Lawsuit. On June 29, 2007, the motion to dismiss was granted. The plaintiffs have appealed the order of dismissal, and briefing on the appeal has been completed. Oral argument on the appeal was held on April 18, 2008. We anticipate receiving a decision on the appeal during 2008.

Additionally, in August 2006, a separate derivative action was filed on behalf of Centene Corporation against us and certain of our officers and directors in the Eastern District Court. Plaintiff purported to bring suit derivatively on behalf of the Company against the Company's directors for breach of fiduciary duties, gross mismanagement and waste of corporate assets by reason of the directors' alleged failure to correct the misstatements alleged in the Consolidated Lawsuit discussed above. The derivative complaint largely repeated the allegations in the Consolidated Lawsuit. Based on discussions that have been held with plaintiff's counsel, it is our understanding that plaintiff did not intend to pursue this action unless the Consolidated Lawsuit proceeded past the dismissal stage. The derivative action has been dismissed.

In addition, we routinely are subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters is uncertain, we do not expect the results of any of these matters individually, or in the aggregate, to have a material effect on our financial position or results of operations.

ITEM 1A. Risk Factors.

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

You should carefully consider the risks described below before making an investment decision. The trading price of our common stock could decline due to any of these risks, in which case you could lose all or part of your investment. You should also refer to the other information in this filing, including our consolidated financial statements and related notes, and in our annual report on Form 10-K for the year ended December 31, 2007 and our quarterly report on Form 10-Q for the quarterly period ended March 31, 2008. The risks and uncertainties described below are those that we currently believe may materially affect our Company. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial also may become important factors that affect our Company.

Risks Related to Being a Regulated Entity

Reduction in Medicaid, SCHIP and SSI funding could substantially reduce our profitability.

Most of our revenues come from Medicaid, SCHIP and SSI premiums. The base premium rate paid by each state differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix and member eligibility categories. Future levels of Medicaid, SCHIP and SSI funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Additionally, state and federal entities may make changes to the design of their Medicaid programs resulting in the cancellation or modification of these programs.

For example, in August 2007, the Centers for Medicare & Medicaid Services, or CMS, published a final rule regarding the estimation and recovery of improper payments made under Medicaid and SCHIP. This rule requires a CMS contractor to sample selected states each year to estimate improper payments in Medicaid and SCHIP and create national and state specific error rates. States must provide information to measure improper payments in Medicaid and SCHIP for managed care and fee-for-service. Each state will be selected for review once every three years for each program. States are required to repay CMS the federal share of any overpayments identified.

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On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 to reduce the size of the federal deficit. The Act reduces federal spending by nearly $40 billion over 5 years, including a $5 billion reduction in Medicaid. The Act reduces spending by cutting Medicaid payments for prescription drugs and gives states new power to reduce or reconfigure benefits. This law may also lead to lower Medicaid reimbursements in some states. The Bush administration's budget proposal for fiscal year 2009 proposes cutting Medicaid funding by $17.4 billion in funding reductions over five years. States also periodically consider reducing or reallocating the amount of money they spend for Medicaid, SCHIP and SSI. In recent years, the majority of states have implemented measures to restrict Medicaid, SCHIP and SSI costs and eligibility.

Changes to Medicaid, SCHIP and SSI programs could reduce the number of persons enrolled in or eligible for these programs, reduce the amount of reimbursement or payment levels, or increase our administrative or healthcare costs under those programs, all of which could have a negative impact on our business. We believe that reductions in Medicaid, SCHIP and SSI payments could substantially reduce our profitability. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds.

If SCHIP is not reauthorized or states face shortfalls, our business could suffer.

SCHIP was initially authorized for a period of ten years through 2007. In late 2007, Congress passed two separate SCHIP reauthorization bills that would have expanded SCHIP coverage, however President Bush vetoed each of these bills. Since they could not come to agreement on long-term SCHIP reauthorization terms, President Bush and Congress agreed to extend SCHIP funding through June 30, 2009. We cannot be certain that SCHIP will be reauthorized when current funding expires in 2009, and if it is, what changes might be made to the program following reauthorization. There are differing views as to what should be contained in an SCHIP reauthorization bill. It is unclear how and when these differences will be resolved and therefore we cannot predict the impact that reauthorization will have on our business, assuming SCHIP is reauthorized.

States receive matching funds from the federal government to pay for their SCHIP programs, which matching funds have a per state annual cap. Because of funding caps, there is a risk that these states could experience shortfalls in future years, which could have an impact on our ability to receive amounts owed to us from states in which we have SCHIP contracts.

If any of our state contracts are terminated or are not renewed, our business will suffer.

We provide managed care programs and selected services to individuals receiving benefits under federal assistance programs, including Medicaid, SCHIP and SSI. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. Our contracts with various states are generally intended to run for one or two years and may be extended for one or two additional years if the state or its agent elects to do so. Our current contracts are set to expire or renew between August 31, 2008 and December 31, 2010. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. For example, on August 25, 2006, we received notification from the Kansas Health Policy Authority that FirstGuard Health Plan Kansas, Inc.'s contract with the State would not be renewed or extended, and as a result, our contract ended on December 31, 2006. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds. For example, the Indiana contract under which we operate can be terminated by the State without cause. Our contracts could also be terminated if we fail to perform in accordance with the standards set by state regulatory agencies. If any of our contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, our business will suffer, and our operating results may be materially affected.

If we are unable to participate in SCHIP programs, our growth rate may be limited.

SCHIP is a federal initiative designed to provide coverage for low-income children not otherwise covered by Medicaid or other insurance programs. The programs vary significantly from state to state. Participation in SCHIP programs is an important part of our growth strategy. If states do not allow us to participate or if we fail to win bids to participate, our growth strategy may be materially and adversely affected.

Changes in government regulations designed to protect the financial interests of providers and members rather than our investors could force us to change how we operate and could harm our business.

Our business is extensively regulated by the states in which we operate and by the federal government. The applicable laws and regulations are subject to frequent change and generally are intended to benefit and protect the financial interests of health plan providers and members rather than investors. The enactment of new laws and rules or changes to existing laws and rules or the interpretation of such laws and rules could, among other things:

- force us to restructure our relationships with providers within our network;
- require us to implement additional or different programs and systems;
- mandate minimum medical expense levels as a percentage of premium revenues;
- restrict revenue and enrollment growth;
- require us to develop plans to guard against the financial insolvency of our providers;
- increase our healthcare and administrative costs;
- impose additional capital and reserve requirements; and
- increase or change our liability to members in the event of malpractice by our providers.

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For example, Congress has previously considered various forms of patient protection legislation commonly known as the Patients' Bill of Rights and such legislation may be proposed again. We cannot predict the impact of any such legislation, if adopted, on our business.

Regulations may decrease the profitability of our health plans.

Certain states have enacted regulations which require us to maintain a minimum health benefits ratio, or establish limits on our profitability. Other states require us to meet certain performance and quality metrics in order to receive our full contractual revenue. In certain circumstances, our plans may be required to pay a rebate to the state in the event profits exceed established levels. These regulatory requirements, changes in these requirements or the adoption of similar requirements by our other regulators may limit our ability to increase our overall profits as a percentage of revenues. Certain states, including but not limited to Georgia, Indiana, New Jersey and Texas have implemented prompt-payment laws and are enforcing penalty provisions for failure to pay claims in a timely manner. Failure to meet these requirements can result in financial fines and penalties. In addition, states may attempt to reduce their contract premium rates if regulators perceive our health benefits ratio as too low. Any of these regulatory actions could harm our operating results. Certain states also impose marketing restrictions on us which may constrain our membership growth and our ability to increase our revenues.

We face periodic reviews, audits and investigations under our contracts with state government agencies, and these audits could have adverse findings, which may negatively impact our business.

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

- refunding of amounts we have been paid pursuant to our contracts;
- imposition of fines, penalties and other sanctions on us;
- loss of our right to participate in various markets;
- increased difficulty in selling our products and services; and
- loss of one or more of our licenses.

Failure to comply with government regulations could subject us to civil and criminal penalties.

Federal and state governments have enacted fraud and abuse laws and other laws to protect patients' privacy and access to healthcare. In some states, we may be subject to regulation by more than one governmental authority, which may impose overlapping or inconsistent regulations. Violation of these and other laws or regulations governing our operations or the operations of our providers could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide services, the suspension or revocation of our licenses or our exclusion from participating in the Medicaid, SCHIP and SSI programs. If we were to become subject to these penalties or exclusions as the result of our actions or omissions or our inability to monitor the compliance of our providers, it would negatively affect our ability to operate our business.

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA created civil penalties for, among other things, billing for medically unnecessary goods or services. HIPAA established new enforcement mechanisms to combat fraud and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of most individually identifiable health information. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules.

We may incur significant costs as a result of compliance with government regulations, and our management will be required to devote time to compliance.

Many aspects of our business are affected by government laws and regulations. The issuance of new regulations, or judicial or regulatory guidance regarding existing regulations, could require changes to many of the procedures we currently use to conduct our business, which may lead to additional costs that we have not yet identified. We do not know whether, or the extent to which, we will be able to recover from the states our costs of complying with these new regulations. The costs of any such future compliance efforts could have a material adverse effect on our business. We have already expended significant time, effort and financial resources to comply with the privacy and security requirements of HIPAA. We cannot predict whether states will enact stricter laws governing the privacy and security of electronic health information. If any new requirements are enacted at the state or federal level, compliance would likely require additional expenditures and management time.

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In addition, the Sarbanes-Oxley Act of 2002, as well as rules subsequently implemented by the SEC and the New York Stock Exchange, or the NYSE, have imposed various requirements on public companies, including requiring changes in corporate governance practices. Our management and other personnel will continue to devote time to these compliance initiatives.

The Sarbanes-Oxley Act requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on the effectiveness of our internal controls over our financial reporting as required by Section 404 of the Sarbanes-Oxley Act. Our testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 requires that we incur substantial accounting expense and expend significant management efforts. Moreover, if we are not able to comply with the requirements of Section 404, or if we or our independent registered public accounting firm identifies deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the NYSE, SEC or other regulatory authorities, which would require additional financial and management resources.

Changes in healthcare law and benefits may reduce our profitability.

Numerous proposals relating to changes in healthcare law have been introduced, some of which have been passed by Congress and the states in which we operate or may operate in the future. Changes in applicable laws and regulations are continually being considered, and interpretations of existing laws and rules may also change from time to time. We are unable to predict what regulatory changes may occur or what effect any particular change may have on our business. For example, these changes could reduce the number of persons enrolled or eligible to enroll in Medicaid, reduce the reimbursement or payment levels for medical services or reduce benefits included in Medicaid coverage. We are also unable to predict whether new laws or proposals will favor or hinder the growth of managed healthcare in general. Legislation or regulations that require us to change our current manner of operation, benefits provided or our contract arrangements may seriously harm our operations and financial results.

For example, in August 2007 CMS issued guidance that imposes new requirements on states that cover children in families with incomes above 250% of the federal poverty level. Under these new requirements, applicable states must provide assurances to CMS that the state has enrolled at least 95% of the Medicaid and SCHIP eligible children in the state who are in families with incomes below 200% of the federal poverty level in Medicaid or SCHIP and that the number of children insured through private employers has not decreased by more than two percentage points over the prior five year period. Three states in which we have SCHIP contracts, Georgia, New Jersey and Wisconsin, are subject to these new regulations. If they are unable to meet these new requirements, they will be unable to continue to cover children in families with incomes above 250% of the federal poverty level, which would likely decrease our membership in such states. Many states object to these new requirements as unduly burdensome and likely to result in a decrease in the number of children covered by SCHIP, and some states, including New Jersey, are pursuing legal challenges against CMS in relation to these new requirements. CMS expects states to comply with the new requirements within 12 months of the issuance of the guidance. On May 7, 2008, CMS issued a letter that clarifies its interpretation of several parts of the August 17, 2007 letter, but it does not change any of the requirements. The May 7, 2008 letter also confirms that CMS will negotiate compliance with the directive on a state-by-state basis. We cannot predict whether legal challenges to the new policy will be successful or whether the reauthorized version of SCHIP will expressly address these new requirements. We cannot predict the impact these requirements will have on our revenue if changes are implemented in states in which we serve SCHIP beneficiaries.

If a state fails to renew a required federal waiver for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may administer Medicaid managed care programs pursuant to demonstration programs or required waivers of federal Medicaid standards. Waivers and demonstration programs are generally approved for two year periods and can be renewed on an ongoing basis if the state applies. We have no control over this renewal process. If a state does not renew such a waiver or demonstration program or the Federal government denies a state's application for renewal, membership in our health plan in the state could decrease and our business could suffer.

Changes in federal funding mechanisms may reduce our profitability.

The Bush administration previously proposed a major long-term change in the way Medicaid and SCHIP are funded. The proposal, if adopted, would allow states to elect to receive, instead of federal matching funds, combined Medicaid-SCHIP "allotments" for acute and long-term healthcare for low-income, uninsured persons. Participating states would be given flexibility in designing their own health insurance programs, subject to federally-mandated minimum coverage requirements. It is uncertain whether this proposal will be enacted. Accordingly, it is unknown whether or how many states might elect to participate or how their participation may affect the net amount of funding available for Medicaid and SCHIP programs. If such a proposal is adopted and decreases the number of persons enrolled in Medicaid or SCHIP in the states in which we operate or reduces the volume of healthcare services provided, our growth, operations and financial performance could be adversely affected.

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On May 29, 2007, CMS issued a final rule that would reduce states' use of intergovernmental transfers for the states' share of Medicaid program funding. By restricting the use of intergovernmental transfers, this rule may restrict some states' funding for Medicaid, which could adversely affect our growth, operations and financial performance. On May 25, 2007, President Bush signed an Iraq war supplemental spending bill that included a one-year moratorium on the effectiveness of the final rule. On June 30, 2008, President Bush signed another Iraq war supplemental spending bill that extends the moratorium on the effectiveness of the final rule until April 1, 2009. We cannot predict whether the rule will ever be implemented and if it is, what impact it will have on our business.

Recent legislative changes in the Medicare program may also affect our business. For example, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 revised cost-sharing requirements for some beneficiaries and requires states to reimburse the federal Medicare program for costs of prescription drug coverage provided to beneficiaries who are enrolled simultaneously in both the Medicaid and Medicare programs. In its fiscal year 2009 budget proposal, the Bush administration has also proposed to further reduce total federal funding for the Medicaid program by $17.4 billion over the next five years. These changes may reduce the availability of funding for some states' Medicaid programs, which could adversely affect our growth, operations and financial performance. In addition, the Medicare prescription drug benefit interrupted the distribution of prescription drugs to many beneficiaries simultaneously enrolled in both Medicaid and Medicare, prompting several states to pay for prescription drugs on an unbudgeted, emergency basis without any assurance of receiving reimbursement from the federal Medicaid program. These expenses may cause some states to divert funds originally intended for other Medicaid services which could adversely affect our growth, operations and financial performance.

If state regulatory agencies require a statutory capital level higher than the state regulations, we may be required to make additional capital contributions.

Our operations are conducted through our wholly owned subsidiaries, which include health maintenance organizations, or HMOs, and managed care organizations, or MCOs. HMOs and MCOs are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Additionally, state regulatory agencies may require, at their discretion, individual HMOs to maintain statutory capital levels higher than the state regulations. If this were to occur to one of our subsidiaries, we may be required to make additional capital contributions to the affected subsidiary. Any additional capital contribution made to one of the affected subsidiaries could have a material adverse effect on our liquidity and our ability to grow.

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

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

Risks Related to Our Business

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

Our health plans rely on other state-operated systems or sub-contractors to qualify, solicit, educate and assign eligible members into the health plans. The effectiveness of these state operations and sub-contractors can have a material effect on a health plan's enrollment in a particular month or over an extended period. When a state implements new

programs to determine eligibility, new processes to assign or enroll eligible members into health plans, or chooses new contractors, there is an increased potential for an unanticipated impact on the overall number of members assigned into the health plans.

Failure to accurately predict our medical expenses could negatively affect our reported results.

Our medical expenses include estimates of medical expenses incurred but not yet reported, or IBNR. We estimate our IBNR medical expenses monthly based on a number of factors. Adjustments, if necessary, are made to medical expenses in the period during which the actual claim costs are ultimately determined or when criteria used to estimate IBNR change. We cannot be sure that our IBNR estimates are adequate or that adjustments to those estimates will not harm our results of operations. For example, in the three months ended June 30, 2006 we adjusted our IBNR by $9.7 million for adverse medical cost development from the first quarter of 2006. In addition, when we commence operations in a new state or region, we have limited information with which to estimate our medical claims liabilities. For example, we commenced operations in the Atlanta and Central regions of Georgia on June 1, 2006 and the Southwest region of Georgia on September 1, 2006 and, for a period of time, based our estimates on state provided historical actuarial data and limited actual incurred and received data. From time to time in the past, our actual results have varied from our estimates, particularly in times of significant changes in the number of our members. Our failure to estimate IBNR accurately may also affect our ability to take timely corrective actions, further harming our results.

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Receipt of inadequate or significantly delayed premiums would negatively affect our revenues and profitability.

Our premium revenues consist of fixed monthly payments per member and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide healthcare services as established by the state governments. We use a large portion of our revenues to pay the costs of healthcare services delivered to our members. If premiums do not increase when expenses related to medical services rise, our earnings will be affected negatively. In addition, our actual medical services costs may exceed our estimates, which would cause our health benefits ratio, or our expenses related to medical services as a percentage of premium revenue, to increase and our profits to decline. In addition, it is possible for a state to increase the rates payable to the hospitals without granting a corresponding increase in premiums to us. If this were to occur in one or more of the states in which we operate, our profitability would be harmed. In addition, if there is a significant delay in our receipt of premiums to offset previously incurred health benefits costs, our earnings could be negatively impacted.

Failure to effectively manage our medical costs or related administrative costs would reduce our profitability.

Our profitability depends, to a significant degree, on our ability to predict and effectively manage expenses related to health benefits. We have less control over the costs related to medical services than we do over our general and administrative expenses. Because of the narrow margins of our health plan business, relatively small changes in our health benefits ratio can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of use of healthcare services, hospital costs, pharmaceutical costs, major epidemics, new medical technologies and other external factors, including general economic conditions such as inflation levels, are beyond our control and could reduce our ability to predict and effectively control the costs of providing health benefits. We may not be able to manage costs effectively in the future. If our costs related to health benefits increase, our profits could be reduced or we may not remain profitable.

Difficulties in executing our acquisition strategy could adversely affect our business.

Historically, the acquisition of Medicaid and specialty services businesses, contract rights and related assets of other health plans both in our existing service areas and in new markets has accounted for a significant amount of our growth. Many of the other potential purchasers have greater financial resources than we have. In addition, many of the sellers are interested either in (a) selling, along with their Medicaid assets, other assets in which we do not have an interest or (b) selling their companies, including their liabilities, as opposed to the assets of their ongoing businesses.

We generally are required to obtain regulatory approval from one or more state agencies when making acquisitions. In the case of an acquisition of a business located in a state in which we do not currently operate, we would be required to obtain the necessary licenses to operate in that state. In addition, even if we already operate in a state in which we acquire a new business, we would be required to obtain additional regulatory approval if the acquisition would result in our operating in an area of the state in which we did not operate previously, and we could be required to renegotiate provider contracts of the acquired business. We cannot assure you that we would be able to comply with these regulatory requirements for an acquisition in a timely manner, or at all. In deciding whether to approve a proposed acquisition, state regulators may consider a number of factors outside our control, including giving preference to competing offers made by locally owned entities or by not-for-profit entities.

We also may be unable to obtain sufficient additional capital resources for future acquisitions. If we are unable to effectively execute our acquisition strategy, our future growth will suffer and our results of operations could be harmed.

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

We pursue acquisitions of other companies or businesses from time to time. Although we review the records of companies or businesses we plan to acquire, even an in-depth review of records may not reveal existing or potential problems or permit us to become familiar enough with a business to assess fully its capabilities and deficiencies. As a result, we may assume unanticipated liabilities or adverse operating conditions, or an acquisition may not perform as well as expected. We face the risk that the returns on acquisitions will not support the expenditures or indebtedness incurred to acquire such businesses, or the capital expenditures needed to develop such businesses. We also face the risk that we will not be able to integrate acquisitions into our existing operations effectively without substantial expense, delay or other operational or financial problems. Integration may be hindered by, among other things, differing procedures, including internal controls, business practices and technology systems. We may need to divert more management resources to integration than we planned, which may adversely affect our ability to pursue other profitable activities.

In addition to the difficulties we may face in identifying and consummating acquisitions, we will also be required to integrate and consolidate any acquired business or assets with our existing operations. This may include the integration of:

- additional personnel who are not familiar with our operations and corporate culture;
- provider networks that may operate on different terms than our existing networks;
- existing members, who may decide to switch to another healthcare plan; and
- disparate administrative, accounting and finance, and information systems.

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Additionally, our growth strategy includes start-up operations in new markets or new products in existing markets. We may incur significant expenses prior to commencement of operations and the receipt of revenue. As a result, these start-up operations may decrease our profitability. In the event we pursue any opportunity to diversify our business internationally, we would become subject to additional risks, including, but not limited to, political risk, an unfamiliar regulatory regime, currency exchange risk and exchange controls, cultural and language differences, foreign tax issues, and different labor laws and practices.

Accordingly, we may be unable to identify, consummate and integrate future acquisitions or start-up operations successfully or operate acquired or new businesses profitably.

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

We are seeking to diversify our business lines into areas that complement our Medicaid business in order to grow our revenue stream and balance our dependence on Medicaid risk reimbursement. In order to diversify our business, we must succeed in selling the services of our specialty subsidiaries not only to our managed care plans, but to programs operated by third-parties. Some of these third-party programs may compete with us in some markets, and they therefore may be unwilling to purchase specialty services from us. In any event, the offering of these services will require marketing activities that differ significantly from the manner in which we seek to increase revenues from our Medicaid programs. Our inability to market specialty services to other programs may impair our ability to execute our business strategy.

Failure to achieve timely profitability in any business would negatively affect our results of operations.

Start-up costs associated with a new business can be substantial. For example, in order to obtain a certificate of authority in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to obtain a state contract and process claims. If we were unsuccessful in obtaining the necessary license, winning the bid to provide service or attracting members in numbers sufficient to cover our costs, any new business of ours would fail. We also could be obligated by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or recover start-up costs. The expenses associated with starting up a new business could have a significant impact on our results of operations if we are unable to achieve profitable operations in a timely fashion.

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

Operations in a few states have accounted for most of our premium revenues to date. If we were unable to continue to operate in any of our current states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. For example, our Medicaid contract with Kansas, which terminated December 31, 2006, together with our Medicaid contract with Missouri accounted for $317.0 million in revenue for the year ended December 31, 2006. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on legislative or other governmental or regulatory actions and decisions, economic conditions and similar factors in those states. Our inability to continue to operate in any of the states in which we operate would harm our business.

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

We compete for members principally on the basis of size and quality of provider network, benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state

Medicaid programs that reimburse providers as care is provided. Subject to limited exceptions by federally approved state applications, the federal government requires that there be choices for Medicaid recipients among managed care programs. Voluntary programs and mandated competition may limit our ability to increase our market share.

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

In addition, in order to increase our membership in the markets we currently serve, we believe that we must continue to develop and implement community-specific products, alliances with key providers and localized outreach and educational programs. If we are unable to develop and implement these initiatives, or if our competitors are more successful than we are in doing so, we may not be able to further penetrate our existing markets.

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

Our profitability depends, in large part, upon our ability to contract favorably with hospitals, physicians and other healthcare providers. Our provider arrangements with our primary care physicians, specialists and hospitals generally may be cancelled by either party without cause upon 90 to 120 days prior written notice. We cannot assure you that we will be able to continue to renew our existing contracts or enter into new contracts enabling us to service our members profitably.

From time to time providers assert or threaten to assert claims seeking to terminate noncancelable agreements due to alleged actions or inactions by us. Even if these allegations represent attempts to avoid or renegotiate contractual terms that have become economically disadvantageous to the providers, it is possible that in the future a provider may pursue such a claim successfully. In addition, we are aware that other managed care organizations have been subject to class action suits by physicians with respect to claim payment procedures, and we may be subject to similar claims. Regardless of whether any claims brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively.

We will be required to establish acceptable provider networks prior to entering new markets. We may be unable to enter into agreements with providers in new markets on a timely basis or under favorable terms. If we are unable to retain our current provider contracts or enter into new provider contracts timely or on favorable terms, our profitability will be harmed.

We may be unable to attract and retain key personnel.

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

Negative publicity regarding the managed care industry may harm our business and operating results.

The managed care industry has received negative publicity. This publicity has led to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. These factors may adversely affect our ability to market our services, require us to change our services, and increase the regulatory burdens under which we operate. Any of these factors may increase the costs of doing business and adversely affect our operating results.

Claims relating to medical malpractice could cause us to incur significant expenses.

Our providers and employees involved in medical care decisions may be subject to medical malpractice claims. In addition, some states, including Texas, have adopted legislation that permits managed care organizations to be held liable for negligent treatment decisions or benefits coverage determinations. Claims of this nature, if successful, could result in substantial damage awards against us and our providers that could exceed the limits of any applicable insurance coverage. Therefore, successful malpractice or tort claims asserted against us, our providers or our employees could adversely affect our financial condition and profitability. Even if any claims brought against us are unsuccessful or without merit, they would still be time consuming and costly and could distract our management's

attention. As a result, we may incur significant expenses and may be unable to operate our business effectively.

Loss of providers due to increased insurance costs could adversely affect our business.

Our providers routinely purchase insurance to help protect themselves against medical malpractice claims. In recent years, the costs of maintaining commercially reasonable levels of such insurance have increased dramatically, and these costs are expected to increase to even greater levels in the future. As a result of the level of these costs, providers may decide to leave the practice of medicine or to limit their practice to certain areas, which may not address the needs of Medicaid participants. We rely on retaining a sufficient number of providers in order to maintain a certain level of service. If a significant number of our providers exit our provider networks or the practice of medicine generally, we may be unable to replace them in a timely manner, if at all, and our business could be adversely affected.

Growth in the number of Medicaid-eligible persons during economic downturns could cause our operating results to suffer if state and federal budgets decrease or do not increase.

Less favorable economic conditions may cause our membership to increase as more people become eligible to receive Medicaid benefits. During such economic downturns, however, state and federal budgets could decrease, causing states to attempt to cut healthcare programs, benefits and rates. We cannot predict the impact of changes in the United States economic environment or other economic or political events, including acts of terrorism or related military action, on federal or state funding of healthcare programs or on the size of the population eligible for the programs we operate. If federal funding decreases or remains unchanged while our membership increases, our results of operations will suffer.

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Growth in the number of Medicaid-eligible persons may be countercyclical, which could cause our operating results to suffer when general economic conditions are improving.

Historically, the number of persons eligible to receive Medicaid benefits has increased more rapidly during periods of rising unemployment, corresponding to less favorable general economic conditions. Conversely, this number may grow more slowly or even decline if economic conditions improve. Therefore, improvements in general economic conditions may cause our membership levels to decrease, thereby causing our operating results to suffer, which could lead to decreases in our stock price during periods in which stock prices in general are increasing.

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

Our operations depend significantly on effective information systems. The information gathered and processed by our information systems assists us in, among other things, monitoring utilization and other cost factors, processing provider claims, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status and other information.

Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs and regulatory requirements. Moreover, our acquisition activity requires frequent transitions to or from, and the integration of, various information systems. We regularly upgrade and expand our information systems' capabilities. If we experience difficulties with the transition to or from information systems or are unable to properly maintain or expand our information systems, we could suffer, among other things, from operational disruptions, loss of existing members and difficulty in attracting new members, regulatory problems and increases in administrative expenses. In addition, our ability to integrate and manage our information systems may be impaired as the result of events outside our control, including acts of nature, such as earthquakes or fires, or acts of terrorists.

We rely on the accuracy of eligibility lists provided by state governments. Inaccuracies in those lists would negatively affect our results of operations.

Premium payments to us are based upon eligibility lists produced by state governments. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we had made related payments to providers and were unable to recoup such payments from the providers.

We may not be able to obtain or maintain adequate insurance.

We maintain liability insurance, subject to limits and deductibles, for claims that could result from providing or failing to provide managed care and related services. These claims could be substantial. We believe that our present insurance coverage and reserves are adequate to cover currently estimated exposures. We cannot assure you that we will be able to obtain adequate insurance coverage in the future at acceptable costs or that we will not incur significant liabilities in excess of policy limits.

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

We are a defendant from time to time in lawsuits and regulatory actions relating to our business. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and operating results. In

addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and require significant attention from our management. For example, in 2006, we were named in two securities class action lawsuits. In addition, we may in the future be the target of similar litigation. As with other litigation, securities litigation could be costly and time consuming, require significant attention from our management and could harm our business and operating results.

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

Issuer Purchases of Equity Securities (1)
Second Quarter 2008

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs
April 1 – April 30, 2008	48,465	$ 13.68	48,400	2,742,809
May 1 – May 31, 2008	109,400	18.40	109,400	2,633,409
June 1 – June 30, 2008	189,567	19.45	189,567	2,443,842
TOTAL	347,432	$ 18.32	347,367	2,443,842

(1) On November 7, 2005 our Board of Directors adopted a stock repurchase program of up to 4,000,000 shares, which extends through October 31, 2008. During the three months ended June 30, 2008, we repurchased 65 shares outside of this publicly announced program.

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

We held our annual meeting of stockholders on April 22, 2008. At the meeting, Michael F. Neidorff, Richard A. Gephardt and John R. Roberts were re-elected as Class I Directors. The votes with respect to each nominee are set forth below:

	Total Vote For Each Director	Total Vote Withheld From Each Director
Mr. Neidorff	34,159,963	5,246,170
Mr. Gephardt	33,970,921	5,435,212
Mr. Roberts	34,446,002	4,960,131

Additional directors of the Company whose terms of office continued after the meeting are Steve Bartlett, Robert K. Ditmore, Fredrick H. Eppinger, Pamela A. Joseph, David L. Steward and Tommy G. Thompson.

Also at the meeting, the following actions were taken:

- the selection of KPMG LLP as the Company's independent registered public accounting firm for the fiscal year ending December 31, 2008 was ratified; and
- amendments to the 2003 Stock Incentive Plan were approved.

The votes are set forth below:

	Total Vote For	Total Vote Against	Total Vote Abstain	Total Broker Non-Votes
KPMG LLP	39,164,926	230,844	10,362	-
	28,738,749	6,674,894	20,322	3,972,168

2003 Stock Incentive Plan

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ITEM 6. Exhibits.

Exhibits.

EXHIBIT NUMBER	DESCRIPTION
10.1	Notice of Renewal for fiscal year 2009 between Peach State Health Plan, Inc. and Georgia Department of Community Health.
10.2	2003 Stock Incentive Plan, as amended, incorporated herein by reference to Exhibit 10.1 to Form 8-K filed April 25, 2008.
12.1	Computation of ratio of earnings to fixed charges.
31.1	Certification of Chairman, President and Chief Executive Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Executive Vice President and Chief Financial Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chairman, President and Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Executive Vice President and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized as of July 22, 2008.

CENTENE CORPORATION

By:	/s/ MICHAEL F. NEIDORFF Chairman, President and Chief Executive Officer (principal executive officer)
By:	/s/ ERIC R. SLUSSER Executive Vice President and Chief Financial Officer (principal financial and accounting officer)