CENTENE CORP
Form 10-Q/A
December 17, 2004
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SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, DC 20549

FORM 10-Q/A

Amendment No. 1

(Mark One)

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

For the quarterly period ended September 30, 2004

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 000-33395

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, Suite 800	
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 an accelerated filer (as defined in Rule 12b-2 of the Act). x Yes ¨ No

As of October 20, 2004, the registrant had 41,045,656 shares of common stock outstanding.

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CENTENE CORPORATION

QUARTERLY REPORT ON FORM 10-Q/A

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This amendment to our quarterly report on Form 10-Q for our quarterly period ended September 30, 2004 has been filed to reflect the following changes:

All share and per share information has been adjusted to give effect to a two-for-one stock split in the form of a 100% stock dividend payable on December 17, 2004 to stockholders of record on November 24, 2003.

In Item 2. Management s Discussion and Analysis of Financial Condition and Results of Operations, we have clarified our presentation of certain non-GAAP financial information, principally by revising the two tables and the final paragraph under Revenue and Expense Discussion and Key Metrics Operating Expenses at page 10 below.

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PART I

FINANCIAL INFORMATION

ITEM 1. ***Financial Statements***

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

(In thousands, except share data)

	September 30, 2004	December 31, 2003
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 88,687	$ 64,346
Premium and related receivables, net of allowances of $470 and $607, respectively	22,739	20,308
Short-term investments, at fair value (amortized cost $43,640 and $15,192, respectively)	43,568	15,160
Deferred income taxes	3,143	2,732
Other current assets	12,561	7,755
Total current assets	170,698	110,301
Long-term investments, at fair value (amortized cost $170,061 and $183,749, respectively)	170,126	184,811
Restricted deposits, at fair value (amortized cost $21,176 and $20,201, respectively)	21,202	20,364
Property, software and equipment	28,831	23,106
Goodwill	17,142	13,066
Other intangible assets	6,808	6,294
Other assets	6,346	4,750
Total assets	$ 421,153	$ 362,692
LIABILITIES AND STOCKHOLDERS EQUITY		
Current liabilities:		
Medical claims liabilities	$ 126,394	$ 106,569
Accounts payable and accrued expenses	21,907	17,965
Unearned revenue	3,670	3,673
Current portion of long-term debt and notes payable	288	579
Total current liabilities	152,259	128,786
Long-term debt	7,400	7,616

Other liabilities	5,571	6,175
Total liabilities	165,230	142,577
Stockholders equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; issued and outstanding 41,040,052 and 40,263,848 shares, respectively	41	40
Additional paid-in capital	161,593	157,360
Accumulated other comprehensive income:		
Unrealized gain on investments, net of tax	12	740
Retained earnings	94,277	61,975
Total stockholders equity	255,923	220,115
Total liabilities and stockholders equity	$ 421,153	$ 362,692

See notes to consolidated financial statements.

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CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF EARNINGS

(In thousands, except share data)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2004	2003	2004	2003
	(Unaudited)		(Unaudited)	
Revenues:				
Premiums	$ 251,536	$ 196,173	$ 705,556	$ 555,285
Services	2,207	2,580	7,320	7,134
Total revenues	253,743	198,753	712,876	562,419
Expenses:				
Medical costs	202,974	160,812	570,720	460,123
Cost of services	2,111	2,681	6,149	6,269
General and administrative expenses	32,187	22,620	88,915	62,904
Total operating expenses	237,272	186,113	665,784	529,296
Earnings from operations	16,471	12,640	47,092	33,123
Other income (expense):				
Investment and other income	1,683	1,245	4,529	3,476
Interest expense	(126)	(71)	(317)	(102)
Earnings before income taxes	18,028	13,814	51,304	36,497
Income tax expense	6,677	5,110	19,002	13,805
Minority interest				881
Net earnings	$ 11,351	$ 8,704	$ 32,302	$ 23,573
Earnings per share:				
Basic earnings per common share	$ 0.28	$ 0.24	$ 0.79	$ 0.69
Diluted earnings per common share	$ 0.26	$ 0.22	$ 0.74	$ 0.64
Weighted average number of shares outstanding:				
Basic	40,972,858	36,861,426	40,693,804	34,189,242
Diluted	43,640,180	39,684,290	43,364,120	36,878,100

See notes to consolidated financial statements.

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CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS

(In thousands)

	Nine Months Ended September 30,	
	2004	**2003**
	(Unaudited)	
Cash flows from operating activities:		
Net earnings	$ 32,302	$ 23,573
Adjustments to reconcile net earnings to net cash provided by operating activities		
Depreciation and amortization	7,219	4,299
Stock compensation expense	44	232
Minority interest		(881)
Gain on sale of investments	(212)	(1,188)
Changes in assets and liabilities		
Premium and related receivables	(2,431)	(4,132)
Other current assets	(4,803)	(849)
Deferred income taxes	(303)	452
Other assets	(1,873)	363
Medical claims liabilities	19,825	558
Accounts payable and accrued expenses	5,184	(396)
Other operating activities	2,523	293
Net cash provided by operating activities	57,475	22,324
Cash flows from investing activities:		
Purchase of property, software and equipment	(9,487)	(16,242)
Purchase of investments	(207,385)	(291,462)
Sales and maturities of investments	188,918	202,306
Acquisitions, net of cash acquired	(7,005)	(3,218)
Net cash used in investing activities	(34,959)	(108,616)
Cash flows from financing activities:		
Reduction of long-term debt and notes payable	(507)	(24)
Extinguishment of acquired liabilities		(1,218)
Proceeds from stock options and employee stock purchase plan	2,332	803
Net proceeds from issuance of common stock		81,403
Proceeds from borrowings		8,581
Cash paid for fractional share impact of stock split		(3)
Net cash provided by financing activities	1,825	89,542
Net increase in cash and cash equivalents	24,341	3,250
Cash and cash equivalents, beginning of period	64,346	59,656

Cash and cash equivalents, end of period	$ 88,687	$ 62,906
Interest paid	$ 324	$ 85
Income taxes paid	$ 18,844	$ 13,479

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

Centene Corporation (Centene or the Company) provides multi-line managed care programs and related services to individuals receiving benefits under government subsidized programs including Medicaid, Supplemental Security Income (SSI), and the State Children s Health Insurance Program (SCHIP). Centene s Medicaid Managed Care segment operates under its own state licenses in Indiana, New Jersey, Ohio, Texas and Wisconsin and contracts with other managed care organizations to provide risk and nonrisk management services. As of January 1, 2004, the Company commenced operations in Ohio. Centene s Specialty Services segment contracts with other healthcare organizations, as well as Centene owned companies, to provide specialty services including behavioral health, nurse triage and treatment compliance.

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 latest fiscal year ended December 31, 2003. Accordingly, footnote disclosures, which would substantially duplicate the disclosures contained in the December 31, 2003 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 2003 amounts in the consolidated financial statements have been reclassified to conform to the 2004 presentation. These reclassifications have no effect on net earnings or stockholders equity as previously reported.

The Company accounts for stock-based compensation under APB Opinion No. 25, Accounting for Stock Issued to Employees. The Company has adopted the disclosure-only provisions of SFAS No. 123, Accounting for Stock-Based Compensation, and SFAS No. 148, Accounting for Stock-Based Compensation-Transition and Disclosure. The following table illustrates the effect on net earnings and earnings per share if the fair value based method had been applied to all awards.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2004	2003	2004	2003

Net earnings	$ 11,351	$ 8,704	$ 32,302	$ 23,573
Pro forma stock-based employee compensation expense determined under fair value based method, net of related tax effects	901	446	2,331	1,049
Pro forma net earnings	$ 10,450	$ 8,258	$ 29,971	$ 22,524
Basic earnings per common share:				
As reported	$ 0.28	$ 0.24	$ 0.79	$ 0.69
Pro forma	0.26	0.22	0.74	0.66
Diluted earnings per common share:				
As reported	$ 0.26	$ 0.22	$ 0.74	$ 0.64
Pro forma	0.24	0.21	0.69	0.61

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3. Acquisitions

FirstGuard

In September 2004, the Company announced a definitive agreement to purchase two health plan entities in Kansas and Missouri. The purchase price of approximately $93,000 plus transaction costs will be allocated to the assets acquired and liabilities assumed according to estimated fair values. The transaction is anticipated to close by the first quarter of 2005 subject to regulatory approvals.

Family Health Plan, Inc.

Effective January 1, 2004, the Company commenced operations in Ohio through the acquisition of certain Medicaid-related assets from Family Health Plan, Inc. for a purchase price of approximately $6,900. The cost has been allocated to the assets acquired and liabilities assumed according to estimated fair values.

The purchase price allocation resulted in identified intangible assets of $1,800, representing purchased contract rights, provider network and a non-compete agreement. The intangibles are being amortized over periods ranging from five to ten years. In addition, goodwill approximated $5,100, which is deductible for tax purposes.

Cenpatico Behavioral Health

During 2003, the Company acquired a 100% ownership interest in Group Practice Affiliates, LLC (GPA), a behavioral healthcare services company (63.7% in March 2003 and 36.3% in August 2003). In September 2004, the Company renamed this subsidiary Cenpatico Behavioral Health. The consolidated financial statements include the results of operations of Cenpatico Behavioral Health since March 1, 2003. The Company paid $1,800 and assumed net liabilities of approximately $2,070 for its purchase of Cenpatico Behavioral Health. The cost to acquire the ownership interest has been allocated to the assets acquired and liabilities assumed according to estimated fair values. The allocation has resulted in goodwill of $3,870 which is not deductible for tax purposes.

4. Earnings Per Share

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

	Three Months Ended September 30,	Nine Months Ended September 30,

	2004	2003	2004	2003
Net earnings	$ 11,351	$ 8,704	$ 32,302	$ 23,573
Shares used in computing per share amounts:				
Weighted average number of common shares outstanding	40,972,858	36,861,426	40,693,804	34,189,242
Common stock equivalents (as determined by applying the treasury stock method)	2,667,322	2,822,864	2,670,316	2,688,858
Weighted average number of common shares and potential dilutive common shares outstanding	43,640,180	39,684,290	43,364,120	36,878,100
Basic earnings per common share	$ 0.28	$ 0.24	$ 0.79	$ 0.69
Diluted earnings per common share	$ 0.26	$ 0.22	$ 0.74	$ 0.64

5. Contingencies

Aurora Health Care, Inc. (Aurora) provides medical professional services to the Company s Wisconsin health plan subsidiary. In May 2003, Aurora filed a lawsuit in the Milwaukee County Circuit Court claiming the Company had failed to adequately reimburse Aurora for services rendered during the period from 1998 to the present. The claim seeks damages totaling $9,400. The Company disputes the claim, has filed answer and discovery requests against Aurora, and plans to defend against the matter.

The Company is routinely subject to legal proceedings in the normal course of business. While the ultimate resolution of such matters are uncertain, the Company does not expect the result of these matters to have a material effect on its financial position or results of operations.

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6. Segment Information

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 makers to evaluate all results of operations.

Centene operates in two segments: Medicaid Managed Care and Specialty Services. The Medicaid Managed Care segment consists of Centene s health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene s specialty companies including behavioral health, nurse triage and treatment compliance functions.

Segment information for the three months ended September 30, 2004, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 251,944	$ 1,799	$	$ 253,743
Revenue from internal customers	15,307	5,358	(20,665)	
Total revenue	$ 267,251	$ 7,157	$ (20,665)	$ 253,743
Earnings before income taxes	$ 18,716	$ (688)	$	$ 18,028

Segment information for the three months ended September 30, 2003, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 196,195	$ 2,558	$	$ 198,753
Revenue from internal customers	6,752	4,113	(10,865)	
Total revenue	$ 202,947	$ 6,671	$ (10,865)	$ 198,753
Earnings before income taxes	$ 13,416	$ 398	$	$ 13,814

Segment information for the nine months ended September 30, 2004, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total

Revenue from external customers	$ 706,790	$ 6,086	$	$ 712,876
Revenue from internal customers	44,864	15,135	(59,999)	
Total revenue	$ 751,654	$ 21,221	$ (59,999)	$ 712,876
Earnings before income taxes	$ 52,178	$ (874)	$	$ 51,304

Segment information for the nine months ended September 30, 2003, follows:

	Medicaid Managed Care	**Specialty Services**	**Eliminations**	**Consolidated Total**
Revenue from external customers	$ 555,391	$ 7,028	$	$ 562,419
Revenue from internal customers	10,847	7,957	(18,804)	
Total revenue	$ 566,238	$ 14,985	$ (18,804)	$ 562,419
Earnings before income taxes	$ 33,869	$ 2,628	$	$ 36,497

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7. Comprehensive Earnings

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2004	2003	2004	2003
Net earnings	$ 11,351	$ 8,704	$ 32,302	$ 23,573
Reclassification adjustment, net of tax	224	(188)	(354)	(474)
Change in unrealized (loss) gain on investments, net of tax	1,257	461	(374)	864
Total comprehensive earnings	$ 12,832	$ 8,977	$ 31,574	$ 23,963

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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, 2003. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth below under Factors that May Affect Future Results and the Trading Price of Our Common Stock.

OVERVIEW

We are a multi-line managed care organization that provides Medicaid and Medicaid-related programs and related services to organizations and individuals through government subsidized programs, including Medicaid, Supplemental Security Income (SSI) and the State Children s Health Insurance Program (SCHIP). We have health plans in Indiana, New Jersey, Ohio, Texas and Wisconsin. We also provide specialty services in each of the states where we have health plans as well as in Arizona, California and Colorado. These specialty services include behavioral health, nurse triage and treatment compliance.

RECENT ACQUISITIONS

Effective January 1, 2004, we commenced operations in Ohio through the acquisition of the Medicaid-related assets of Family Health Plan, Inc. (FHP) for a purchase price of $6.9 million. We are now serving 23,500 members in Toledo, Ohio, a new market for us. The results of operations of this entity are included in our consolidated financial statements beginning January 1, 2004. The purchase price allocation resulted in identified intangible assets of $1.8 million, representing purchased contract rights, provider network and a non-compete agreement, and goodwill of $5.1 million. The contract rights, provider network and non-compete agreement are being amortized over periods ranging from five to ten years.

Effective August 1, 2003, we acquired the Medicaid-related contract rights of HMO Blue Texas in the San Antonio, Texas market. This transaction allows us to serve approximately 17,000 additional members in the state. The purchase price of $1.0 million was allocated to acquired contracts. The contracts are being amortized on a straight-line basis over a period of five years, the expected period of benefit.

During 2003, we acquired a 100% ownership interest in Group Practice Affiliates, LLC, a behavioral healthcare services company (63.7% in March 2003 and 36.3% in August 2003). In September 2004, we renamed this subsidiary Cenpatico Behavioral Health. This acquisition is consistent with our strategy to provide diversified medical services to the managed Medicaid population. We paid an aggregate purchase price of $1.8 million for Cenpatico Behavioral Health, assumed net liabilities of $2.1 million and recorded goodwill of $3.9 million related to the acquisition.

In March 2003, we purchased certain assets of ScriptAssist, a treatment compliance company. We are administering the purchased contracts under the ScriptAssist name. ScriptAssist uses various approaches and medical expertise to promote adherence to prescription drugs. The asset acquisition is consistent with our strategy to provide diversified medical services to the managed Medicaid population. The purchase price of $563,000 was allocated to acquired contracts. We are amortizing the contracts on a straight-line basis over five years, the expected period of benefit.

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REVENUE AND EXPENSE DISCUSSION AND KEY METRICS

Revenues

We generate revenues in our Medicaid Managed Care segment primarily from premiums we receive from the states in which we operate to provide health benefits to our members. We receive a fixed premium per member per month pursuant to our state contracts. We generally receive premiums during the month we provide services and recognize premium revenue during the period in which we are obligated to provide services to our members.

Our Specialty Services companies generate revenue from a variety of sources. Our behavioral health company generates revenue via capitation payments from our health plans and others. It also receives fees for the direct provision of care and certain school programs in Arizona. Our treatment compliance program receives fee income from the manufacturers of pharmaceuticals. Our nurse triage line receives fees from health plans (including our own), physicians and other organizations for providing continuous access to nurse advisors.

Premiums collected in advance are recorded as unearned revenue. Premiums due to us are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and our judgment regarding the collectibility of these accounts. As we generally receive premiums during the month in which services are provided, the allowance is typically not significant in comparison to total premium revenue and does not have a material impact on the presentation of our financial condition, changes in financial position or results of operations.

The primary drivers of our increasing revenue have been membership growth in our Medicaid Managed Care segment. We have increased our membership through internal growth as well as acquisitions. From September 30, 2003 to September 30, 2004, we increased our membership by 37.4%. The following table sets forth our membership by state:

	September 30,	
	2004	2003
Indiana	150,000	112,100
New Jersey	53,200	52,700
Ohio	23,500	
Texas	250,200	152,100
Wisconsin	164,700	150,200
Total	641,600	467,100

The following table sets forth our membership by line of business:

	September 30,

	2004	2003
Medicaid	479,500	389,200
SCHIP	152,100	68,600
SSI	10,000	9,300
Total	641,600	467,100

During the last 12 months our membership increased by 23,500 members in Ohio due to the acquisition of Medicaid-related assets from FHP and 94,500 members in Texas from the SCHIP Exclusive Provider Organization (EPO) contract effective September 1, 2004. Our membership also increased in each of our markets from additions to our provider networks, increases in counties served and growth in the overall number of Medicaid beneficiaries.

Our Medicaid membership has increased in the last twelve months due to the factors described above. Our SCHIP membership has declined over the same period (excluding the impact of the EPO contract effective September 1, 2004) as a result of administrative or procedural changes implemented by several states to obtain interim or temporary cost relief at a point in time related to SCHIP programs. The impact of the states efforts to at times reduce SCHIP costs is anticipated to result in continued volatility with a trend down in our SCHIP membership, including the EPO membership, for the remainder of 2004.

Operating Expenses

Our operating expenses include medical costs, cost of services, and general and administrative expenses.

Our medical costs include payments to physicians, hospitals, and other providers for healthcare and specialty product claims. Medical costs also include estimates of medical expenses incurred but not yet reported, or IBNR, and estimates of the cost to process

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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 related to fluctuations in provider billing patterns, membership, products and inpatient hospital trends. These estimates are adjusted as more information becomes available. We utilize 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.

Our results of operations depend on our ability to manage expenses related to health benefits and to accurately predict costs incurred. Our health benefits ratio represents medical costs as a percentage of premium revenues and reflects the direct relationship between the premium received and the medical services provided. The table below depicts our health benefits ratios by member category and in total:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2004	2003	2004	2003
Medicaid and SCHIP	80.1%	81.3%	80.3%	82.0%
SSI	92.8	102.9	96.6	103.5
Total	80.7	82.0	80.9	82.9

Our Medicaid and SCHIP ratio decreased in 2004 from 2003 due primarily to initiatives to reduce inappropriate emergency room usage and to establish preferred drug lists. The health benefits ratio for SSI is affected by a low membership base and is subject to greater volatility as a percentage of premiums (although relatively immaterial in total dollars to total medical costs).

Our cost of services expenses include all direct costs to support the local functions responsible for generation of our services revenues. These expenses primarily consist of the salaries and wages of the physicians, clinicians, therapists and teachers who provide the services and expenses related to the clinics and supporting facilities and equipment used to provide services.

Our general and administrative expenses primarily reflect wages and benefits and other administrative costs related to health plans, specialty companies and the centralized functions that support all of our business units. The major centralized functions are claims processing, information systems and finance. Premium taxes are classified as general and administrative expenses. Our general and administrative expense ratio represents general and administrative expenses as a percentage of total revenues and reflects the relationship between revenues earned and the costs necessary to drive those revenues. The following table sets forth the general and administrative expense ratios by business segment and in total:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2004	2003	2004	2003
Medicaid Managed Care	10.5%	10.2%	10.4%	10.3%
Specialty Services	56.0	32.0	51.8	31.0
Total	12.7	11.4	12.5	11.2

The increase in the Medicaid Managed Care general and administrative expense ratio in 2004 reflects the impact of premium taxes enacted in September 2003 in Texas and July 2004 in New Jersey. These taxes totaled $3.7 million in the nine months ended September 30, 2004 and $347,000 in the nine months ended September 30, 2003 and had the effect of increasing our general and administrative expense ratio by 0.5% between years. The 2004 results also included approximately $400,000 of start-up costs associated with the Texas EPO contract.

The Specialty Services ratio may vary depending on the various contracts and nature of the service provided and will have a higher general and administrative expense ratio than the Medicaid Managed Care segment. The quarter ended September 30, 2004 included $445,000 of due diligence costs related to a transaction that we decided not to pursue and costs associated with the closing of our clinic facilities in Texas and California as Cenpatico Behavioral Health fully transitions to a third-party service model for behavioral health services.

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Other Income (Expense)

Other income (expense) consists of investment and other income and interest expense.

Investment income is derived from our cash, cash equivalents and investments. Information about our investments is included below under Liquidity and Capital Resources.

Interest expense reflects mortgage interest on our corporate headquarters building and fees paid to a bank group in conjunction with our credit facility.

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RESULTS OF OPERATIONS

Nine Months Ended September 30, 2004 Compared to Nine Months Ended September 30, 2003

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

	Nine Months Ended September 30,		
			% Change
	2004	2003	2003-2004
Premium revenue	$ 705.6	$ 555.3	27.1%
Services revenue	7.3	7.1	2.6%
Total revenues	712.9	562.4	26.8%
Medical costs	570.7	460.1	24.0%
Cost of services	6.2	6.3	(1.9)%
General and administrative expenses	88.9	62.9	41.4%
Earnings from operations	47.1	33.1	42.2%
Investment and other income, net	4.2	3.4	24.8%
Earnings before income taxes	51.3	36.5	40.6%
Income tax expense	19.0	13.8	37.6%
Minority interest		0.9	
Net earnings	$ 32.3	$ 23.6	37.0%
Diluted earnings per common share	0.74	0.64	15.6%

Revenues

Total revenues for the nine months ended September 30, 2004 increased 26.8% from the comparable period in 2003. This increase was due to organic growth in our existing markets, changes in our member mix by product category, the addition of EPO members in Texas, the purchase of the Texas contracts from HMO Blue, the addition of our Ohio membership through our acquisition of the Medicaid-related assets of FHP and premium rate increases.

Operating Expenses

Medical costs increased 24.0% due to the growth in our membership as discussed above. Our health benefits ratio decreased to 80.9% from 82.9% primarily due to our initiatives to reduce inappropriate emergency room usage and to establish preferred drug lists.

General and administrative expenses increased 41.4% primarily due to expenses for additional staff to support our membership growth, expansion into the Specialty Services segment and the institution of a premium tax in two states.

Other Income

Investment and other income increased 24.8% for the nine months ended September 30, 2004 from the comparable period in 2003. The increase was due to higher investment balances in 2004 primarily as a result of our $81.3 million common stock offering completed in August 2003.

Income Tax Expense

Our effective tax rate in 2004 was 37.0%, compared to 37.8% in 2003. The decrease was primarily due to a lower effective state tax rate.

Earnings Per Share and Shares Outstanding

Our earnings per share calculations reflect an increase in the weighted average shares outstanding in 2004 primarily resulting from the follow-on offering of 6,900,000 shares sold in August 2003.

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Three Months Ended September 30, 2004 Compared to Three Months Ended September 30, 2003

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

	Three Months Ended September 30,		
			% Change
	2004	2003	2003-2004
Premium revenue	$ 251.5	$ 196.1	28.2%
Services revenue	2.2	2.6	(14.5)%
Total revenues	253.7	198.7	27.7%
Medical costs	203.0	160.8	26.2%
Cost of services	2.1	2.7	(21.3)%
General and administrative expenses	32.2	22.6	42.3%
Earnings from operations	16.4	12.6	30.3%
Investment and other income, net	1.6	1.2	32.6%
Earnings before income taxes	18.0	13.8	30.5%
Income tax expense	6.7	5.1	30.7%
Minority interest			
Net earnings	$ 11.3	$ 8.7	30.4%
Diluted earnings per common share	$ 0.26	$ 0.22	18.2%

Revenues

Total revenues for the three months ended September 30, 2004 increased 27.7% from the comparable period in 2003. This increase was due to organic growth in our existing markets, changes in our member mix by product category, the addition of EPO members in Texas, the addition of our Ohio membership through our acquisition of the Medicaid-related assets of FHP and premium rate increases.

Operating Expenses

Medical costs increased 26.2% due to the growth in our membership as discussed above. Our health benefits ratio decreased to 80.7% from 82.0% primarily due to our initiatives to reduce inappropriate emergency room usage and to establish preferred drug lists.

General and administrative expenses increased 42.3% primarily due to expenses for additional staff to support our membership growth and the institution of premium tax in two states.

Other Income

Investment and other income increased 32.6% for the three months ended September 30, 2004 from the comparable period in 2003. The increase was due to higher investment balances in 2004 primarily as a result of our $81.3 million common stock offering completed in August 2003.

Income Tax Expense

Our effective tax rate for the three months ended September 30, 2004 was 37.0%, consistent with the prior year period.

Earnings Per Share and Shares Outstanding

Our earnings per share calculations reflect an increase in the weighted average shares outstanding in 2004 primarily resulting from the follow-on offering of 6,900,000 shares sold in August 2003.

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LIQUIDITY AND CAPITAL RESOURCES

Our operating activities provided cash of $57.5 million in the nine months ended September 30, 2004 compared to $22.3 million in the comparable period in 2003. The increase was primarily due to increased net income in addition to the timing of medical claim liabilities and accounts payable payments.

Our investing activities used cash of $35.0 million in the nine months ended September 30, 2004 compared to $108.6 million in the comparable period in 2003. The largest component of investing activities related to increases in our investment portfolio. Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets within our investment guidelines. 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. As of September 30, 2004, our investment portfolio consisted primarily of fixed-income securities with an average duration of 2.2 years. Cash is invested in investment vehicles such as municipal bonds, corporate bonds, insurance contracts, commercial paper and instruments of the U.S. Treasury. The states in which we operate prescribe the types of instruments in which our regulated subsidiaries may invest their cash. The average annualized portfolio yield was 3.4% for the nine months ended September 30, 2004 and 3.8% for the comparable period in 2003.

Our financing activities provided cash of $1.8 million in the nine months ended September 30, 2004 and provided cash of $89.5 million in the comparable period in 2003. Cash flow from investing and financing activities in 2003 included investing the proceeds of our $81.3 million follow-on offering completed in August 2003.

We spent $9.5 million and $16.2 million in the nine months ended September 30, 2004 and 2003, respectively, on capital assets. We anticipate spending $4.7 million on additional capital expenditures in 2004 related to facility expansions and system upgrades. We also anticipate spending approximately $10 million in the fourth quarter for real estate to support future expansion of our corporate facilities. A portion of the price may be funded through a non-recourse mortgage agreement.

At September 30, 2004, we had working capital, defined as current assets less current liabilities, of $18.4 million as compared to ($18.5) million at December 31, 2003. Our working capital is sometimes negative due to our efforts to increase investment returns through purchases of investments that have maturities of greater than one year and, therefore, are classified as long-term. Our investment policies are also designed to provide liquidity and preserve capital. We manage our short-term and long-term investments to ensure that a sufficient portion is held in investments that are highly liquid and can be sold to fund short-term capital requirements as needed.

Cash, cash equivalents and short-term investments were $132.3 million at September 30, 2004 and $79.5 million at December 31, 2003. Long-term investments were $191.3 million at September 30, 2004 and $205.2 million at December 31, 2003, including restricted deposits of $21.2 million and $20.4 million, respectively. At September 30, 2004, cash and investments held by our unregulated entities totaled $123.3 million while cash and investments held by our regulated entities totaled $200.3 million.

In September 2004, we executed a five-year $100 million Revolving Credit Agreement with various financial institutions and LaSalle Bank National Association as administrative agent and arranger. Borrowings under the agreement will bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. Under our current capital structure, borrowings under the agreement will bear interest at LIBOR plus 1%. This rate may change under differing capital structures over the life of the agreement. The agreement is secured by the common stock and membership interests of our subsidiaries. The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, minimum debt-to-EBITDA ratios and minimum tangible net worth. The agreement will expire in September 2009 or on an earlier date in the instance of a default as defined in the agreement. As of September 30, 2004, we were in compliance with all

covenants and no funds had been drawn under the agreement. In conjunction with this agreement, we cancelled our prior existing $50 million credit facility.

In September 2004, we executed a definitive agreement, subject to regulatory approvals, to purchase two health plan entities, collectively referred to as FirstGuard, in Kansas and Missouri for approximately $93 million plus transaction costs. The purchase, if completed, will be funded from a combination of our available cash and investments and borrowings under our credit facility.

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There were no other material changes outside the ordinary course of our business in lease obligations or other contractual obligations in the nine months ended September 30, 2004. Based on our operating plan, we expect that our available funding will be sufficient to finance our operations, planned acquisition of FirstGuard and capital expenditures for at least 12 months from the date of this filing.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

Our Medicaid Managed Care operations are conducted through our subsidiaries. As managed care organizations, these 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 subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of September 30, 2004, our subsidiaries had aggregate statutory capital and surplus of $85.0 million, compared with the required minimum aggregate statutory capital and surplus requirements of $35.8 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 September 30, 2004, our Ohio, Texas and Wisconsin health plans were in compliance with risk-based capital requirements. Indiana has adopted risk-based capital rules that will take effect as of December 31, 2004. If adopted by New Jersey, risk-based capital may increase the minimum capital required for our health plan in New Jersey. We continue to monitor the requirements in Indiana and New Jersey and do not expect that they will have a material impact on our results of operations, financial position or cash flows.

FORWARD-LOOKING STATEMENTS

This filing contains forward-looking statements that relate to future events or our future financial performance. We have attempted to identify these statements by terminology including believe, anticipate, plan, expect, estimate, intend, seek, goal, may, will, should, negative of these terms or other comparable terminology. 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 section of this filing entitled Management s Discussion and Analysis of Financial Condition and Results of Operations. 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.

Actual results may differ from projections or estimates due to a variety of important factors. Our results of operations and projections of future earnings depend in large part on accurately predicting and effectively managing health benefits and other operating expenses. A variety of factors, including competition, changes in health care practices, changes in federal or state laws and regulations or their interpretations, inflation, provider contract changes, new technologies, government-imposed surcharges, taxes or assessments, reduction in provider payments by governmental payers, major epidemics, disasters and numerous other factors affecting the delivery and cost of healthcare, such as major healthcare providers inability to maintain their operations, may in the future affect our ability to control our medical costs and other operating expenses. Governmental action or business conditions could result in premium revenues not increasing to offset any increase in medical costs

and other operating expenses. Once set, premiums are generally fixed for one-year periods and, accordingly, unanticipated costs during such periods cannot be recovered through higher premiums. The expiration, cancellation or suspension of our Medicaid managed care contracts by the state governments would also negatively impact us. Due to these factors and risks, we cannot give assurances with respect to our future premium levels or our ability to control our future medical costs.

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.

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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 continued government efforts to contain medical costs and may further be affected by state and federal budgetary constraints. For example, in August 2004, the Centers for Medicare & Medicaid Services, or CMS, proposed a rule requiring states to estimate improper payments made under their Medicaid and SCHIP programs, report such overpayments to Congress, and, if necessary, take actions to reduce erroneous payments. Changes to Medicaid, SCHIP and SSI programs could reduce the number of persons enrolled or eligible, reduce the amount of reimbursement or payment levels, or increase our administrative or healthcare costs under those programs. States periodically consider reducing or reallocating the amount of money they spend for Medicaid, SCHIP and SSI. Over the past two years, the majority of states have implemented measures to restrict Medicaid, SCHIP and SSI costs and eligibility. 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 Our Medicaid and SCHIP 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, SSI and SCHIP. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. The contracts expire on various dates between December 31, 2004 and August 31, 2007. Our contracts may be terminated if we fail to perform up to the standards set by state regulatory agencies. In addition, the Indiana contract under which we operate can be terminated by the state without cause. Our contracts are generally intended to run for two years and may be extended for one or two additional years if the state or its contractor elects to do so. 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. If any of our contracts are terminated, not renewed, or renewed on less favorable terms, our business will suffer, and our operating results may be materially affected.

Changes in Government Regulations Designed to Protect Providers and Members Rather than Our Stockholders 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 health plan providers and members rather than stockholders. Changes in existing laws and rules, the enactment of new laws and rules or changing interpretations of these 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 premiums 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 considered various forms of patient protection legislation commonly known as the Patients Bill of Rights and the legislation is currently pending in Congress. We cannot predict the impact of this legislation, if adopted, on our business.

Regulations May Decrease the Profitability of Our Health Plans.

Our Texas plan is required to pay a rebate to the state in the event profits exceed established levels. Similarly, our New Jersey plan is required to pay a rebate to the state in the event its health benefits ratio is less than 80%. 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. The states of 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.

Also, on January 18, 2002, CMS published a final rule that removed a provision contained in the federal Medicaid reimbursement regulations permitting states to reimburse non-state government-owned or operated hospitals for inpatient and outpatient hospital services at amounts up to 150% of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicaid payment principles. The upper payment limit was reduced to 100% of Medicare payments for comparable services. This development in federal regulation decreased the profitability of our health plans.

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. 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, SSI and SCHIP 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. For example, failure to pay our providers promptly could result in the imposition of fines and other penalties. In some states, we may be subject to regulation by more than one governmental authority, which may impose overlapping or inconsistent regulations.

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. Further, HIPAA imposes 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.

Compliance With New Government Regulations May Require Us to Make Significant Expenditures.

On February 20, 2003 HHS published the final HIPAA health data security regulations. The security regulations became effective on April 21, 2003. Compliance with the security regulations is required by April 21, 2005. These regulations will require covered entities to implement

administrative, physical and technical safeguards to protect electronic health information maintained or transmitted by the organization.

The issuance of future judicial or regulatory guidance regarding the interpretation of regulations, the states ability to promulgate stricter rules, and continuing uncertainty regarding many aspects of the regulations implementation may make compliance with the relatively new regulatory landscape difficult. For example, our existing programs and systems may not enable us to comply in all respects with the new security regulations. In order to comply with the regulatory requirements, we will be required to employ additional or different programs and systems, the costs of which were $310,000 in 2003 and are not expected to exceed $500,000 in 2004. Further, compliance with these 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 new regulations and the related compliance costs could have a material adverse effect on our business.

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Changes in Healthcare Law 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 for Medicaid and reduce the reimbursement or payment levels for medical services. More generally, we are unable to predict whether new laws or proposals will favor or hinder the growth of managed healthcare. Legislation or regulations that require us to change our current manner of operation, provide additional benefits or change our contract arrangements may seriously harm our operations and financial results.

Changes in Federal Funding Mechanisms May Reduce Our Profitability.

For fiscal year 2005, the Bush Administration 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, or if so, how it may change from a similar proposal initiated by the Bush Administration in February 2003. 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.

In April 2004, the Bush Administration adopted a new policy that seeks to reduce states use of accounting devices such as intergovernmental transfers for the states share of Medicaid program funding. By restricting the use of intergovernmental transfers as part of states Medicaid contributions, this policy, if continued, may restrict some states funding for Medicaid, which could adversely affect our growth, operations and financial performance.

Recent legislative changes in the Medicare program may also affect our business. For example, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, enacted in December 2003, will, upon taking effect in 2006, revise cost-sharing requirements for some beneficiaries and require 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. These changes may reduce the availability of funding for some states Medicaid programs, which could adversely affect our growth, operations and financial performance.

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.

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 our company as a whole would be limited, which could harm our ability to implement our business strategy.

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Risks Related to Our Business

Receipt of Inadequate Premiums Would Negatively Affect Our Revenues and Profitability.

Nearly all of our revenues are generated by premiums consisting of fixed monthly payments per member. 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 revenues, 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.

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. Historically, our health benefits ratio has fluctuated. For example, our health benefits ratio was 82.4% for the year ended December 31, 2003, but was 88.9% for 1999 and 88.4% for 1998. 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.

Failure to Accurately Predict Our Medical Expenses Could Negatively Affect Our Reported Results.

Our medical expenses include estimates of IBNR medical expenses. 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. 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.

Difficulties in Executing Our Acquisition Strategy Could Adversely Affect Our Business.

Historically, the acquisition of Medicaid 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 of Medicaid assets 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. Furthermore, our credit facility may prohibit some acquisitions without the consent of our bank lender.

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;

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existing 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.

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

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 2003, for example, we acquired Cenpatico Behavioral Health, a behavioral health services company, and purchased contract and name rights of ScriptAssist, a treatment compliance company. 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 Indiana, New Jersey, Ohio, Texas and Wisconsin have accounted for most of our premium revenues to date. If we were unable to continue to operate in each of those states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on legislative actions, 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.

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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.

If We are Unable to Maintain Satisfactory Relationships With Our Provider Networks, Our Profitability Will 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. We do not have an employment agreement with Mr. Neidorff, and we cannot assure you that we will be able to retain his services. 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.

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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 and Stock Prices 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.

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.

We Intend to Expand Our Medicaid Managed Care Business Primarily into Markets Where Medicaid Recipients are Required to Enroll in Managed Care Plans.

We expect to continue to focus our business in states in which Medicaid enrollment in managed care is mandatory. Currently, approximately two-thirds of the states require health plan enrollment for Medicaid eligible participants in all or a portion of their counties. The programs are voluntary in other states. Because we concentrate on markets with mandatory enrollment, we expect the geographic expansion of our Medicaid Managed Care segment to be limited to those states.

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. 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.

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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.

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ITEM 3. ***Quantitative and Qualitative Disclosures About Market Risk.***

INVESTMENTS

As of September 30, 2004, we had short-term investments of $43.6 million and long-term investments of $191.3 million, including restricted deposits of $21.2 million. The short-term investments consist of highly liquid securities with maturities between three and twelve months. The long-term investments consist of municipal, corporate and U.S. agency bonds, life insurance contracts and U.S. Treasury investments 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. These investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold the investments to maturity which would mitigate the risk of a significant increase in market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at September 30, 2004, the fair value of our fixed income investments would decrease by approximately $5.8 million. Declines in interest rates over time will reduce our investment income.

INFLATION

Although the general rate of inflation has remained relatively stable and healthcare cost inflation has stabilized in recent years, the national healthcare cost inflation rate still exceeds 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 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.

COMPLIANCE COSTS

Federal and state regulations governing standards for electronic transactions, data security and confidentiality of patient information have been issued recently. Due to the uncertainty surrounding the regulatory requirements, we cannot be sure that the systems and programs that we have implemented will comply adequately with the security regulations that are ultimately adopted. Implementation of additional systems and programs will be required, the cost of which we estimate not to exceed $500,000 in 2004. Further, compliance with these regulations would 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 our costs of complying with these new regulations from the states.

ITEM 4. ***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 defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act) as of September 30, 2004. Based on this evaluation, our chief executive officer and chief financial officer concluded that, as of September 30, 2004, our disclosure controls and procedures were (1) designed to ensure that material information relating to us, and our consolidated subsidiaries, is made known to our chief executive officer and chief financial officer by others within those entities, particularly during the period in which this report was being prepared, and (2) effective, in that they provide reasonable assurance that information required to be disclosed by us in the reports that we file or submit under the Exchange Act are recorded, processed, summarized and reported within the time periods specified in the SEC s rules and forms.

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 fiscal quarter ended September 30, 2004 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.***

Aurora Health Care, Inc. (Aurora) provides medical professional services to our Wisconsin health plan subsidiary. In May 2003, Aurora filed a lawsuit in the Milwaukee County Circuit Court claiming we had failed to adequately reimburse Aurora for services rendered during the period from 1998 to the present. The claim seeks damages totaling $9.4 million. We dispute the claim, have filed answer and discovery requests against Aurora, and are defending against the matter.

We are routinely subject to legal proceedings in the normal course of business. While the ultimate resolution of such matters are uncertain, we do not expect the result of these matters to have a material effect on our financial position or results of operations.

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

None.

ITEM 3. ***Defaults Upon Senior Securities.***

None.

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

None.

ITEM 5. ***Other Information.***

None.

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ITEM 6. ***Exhibits***

Exhibits.

EXHIBIT NUMBER	DESCRIPTION
10.1*	Centene Corporation Non-Employee Directors Deferred Stock Compensation Plan.
10.2*	Credit Agreement dated as of September 14, 2004 among Centene Corporation, the various financial institutions party hereto and LaSalle Bank National Association.
10.3*	Stock Purchase Agreement by and between Centene Corporation and Swope Community Enterprises, dated September 28, 2004.
31.1	Certification of Chairman and Chief Executive Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Senior Vice President, Chief Financial Officer, Secretary and Treasurer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chairman 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 Senior Vice President, Chief Financial Officer, Secretary and Treasurer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

* Incorporated by reference from the Quarterly Report on Form 10-Q filed with the Securities and Exchange Commission on October 25, 2004.

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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 December 17, 2004.

CENTENE CORPORATION

By: /s/ Michael F. Neidorff

Michael F. Neidorff
Chairman, President and Chief Executive Officer
(principal executive officer)

By: /s/ Karey L. Witty

Karey L. Witty
Senior Vice President, Chief Financial
Officer, Secretary and Treasurer (principal
financial and accounting officer)