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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 March 31, 2003

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	04-1406317
(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)

Regristrant'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 April 25, 2003, the registrant had 10,952,359 shares of common stock outstanding.

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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)

<TABLE>
<CAPTION>

	MARCH 31, 2003	DECEMBER 31, 2002
<S>	(Unaudited) <C>	<C>
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$ 59,970	$ 59,656
Premium and related receivables, net of allowances of $215 and $219, respectively	19,925	16,773
Short-term investments, at fair value (amortized cost $8,724 and $9,687, respectively)	8,719	9,571
Deferred income taxes	1,853	2,846
Other current assets	5,335	4,243
Total current assets	95,802	93,089
LONG-TERM INVESTMENTS, at fair value (amortized cost $85,580 and $78,025, respectively)	87,187	79,666
RESTRICTED DEPOSITS, at fair value (amortized cost $16,322 and $15,561, respectively)	16,533	15,762
PROPERTY AND EQUIPMENT, net	6,998	6,295
INTANGIBLE ASSETS, net	13,308	10,695
DEFERRED INCOME TAXES	630	472
OTHER ASSETS	4,289	4,348
Total assets	$ 224,747	$ 210,327
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES:		
Medical claims liabilities	$ 94,767	$ 91,181
Accounts payable and accrued expenses	13,041	10,748
Other current liabilities	370	--
Total current liabilities	108,178	101,929
OTHER LIABILITIES	6,319	5,334
Total liabilities	114,497	107,263
</TABLE>

MINORITY INTEREST	589	881
STOCKHOLDERS' EQUITY:		
Common stock, $.001 par value; authorized 40,000,000 shares; 10,943,142 and 10,829,099 shares issued and outstanding, respectively	11	11
Additional paid-in capital	72,640	72,377
Accumulated other comprehensive income:		
Net unrealized gain on investments, net of tax	1,141	1,087
Retained earnings	35,869	28,708
Total stockholders' equity	109,661	102,183
Total liabilities and stockholders' equity	$ 224,747	$ 210,327

</TABLE>

The accompanying notes are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF EARNINGS
(IN THOUSANDS, EXCEPT SHARE DATA)

<TABLE>
<CAPTION>

	THREE MONTHS ENDED MARCH 31,	
	2003	2002
	(Unaudited)	
<S>	<C>	<C>
REVENUES:		
Premiums	$ 176,212	$ 95,650
Services	1,222	103
Total revenues	177,434	95,753
EXPENSES:		
Medical costs	146,907	78,944
Cost of services	975	82
General and administrative expenses	19,405	10,465
Total operating expenses	167,287	89,491
Earnings from operations	10,147	6,262
OTHER INCOME (EXPENSE):		
Investment and other income, net	974	915
Interest expense	(27)	--
Earnings before income taxes	11,094	7,177
INCOME TAX EXPENSE	4,233	2,877
MINORITY INTEREST	300	--
Net earnings	$ 7,161	$ 4,300
EARNINGS PER COMMON SHARE, BASIC:		
Net earnings per common share	$ 0.66	$ 0.43
EARNINGS PER COMMON SHARE, DILUTED:		
Net earnings per common share	$ 0.60	$ 0.38
SHARES USED IN COMPUTING PER SHARE AMOUNTS:		
Basic	10,898,849	10,091,348
Diluted	11,838,177	11,317,634

</TABLE>

The accompanying notes are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
(IN THOUSANDS)

<TABLE>
<CAPTION>

	THREE MONTHS ENDED MARCH 31,	
	2003	2002
	(Unaudited)	
<S>	<C>	<C>
CASH FLOWS FROM OPERATING ACTIVITIES:		
Net earnings	$ 7,161	$ 4,300
Adjustments to reconcile net earnings to net cash provided by operating activities --		
Depreciation and amortization	1,379	476
Stock compensation expense	5	4
Minority interest	(300)	--
Gain on sale of investments	(293)	(205)
Changes in assets and liabilities --		
Increase in premium and related receivables	(1,982)	(2,640)
Increase in other current assets	(626)	(2,413)
Decrease in deferred income taxes	803	288
Decrease in other assets	58	--
Increase in medical claims liabilities	3,586	5,363
Decrease in accounts payable and accrued expenses	(187)	(2,869)
Increase in unearned revenues	19	--
Increase in other liabilities	236	--
Net cash provided by operating activities	9,859	2,304
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchase of property and equipment	(684)	(1,338)
Purchase of investments	(42,055)	(6,673)
Sales and maturities of investments	35,218	11,751
Contract acquisitions	(561)	--
Investment in subsidiary	(1,722)	(3,188)
Net cash (used in) provided by investing activities	(9,804)	552
CASH FLOWS FROM FINANCING ACTIVITIES:		
Proceeds from exercise of stock options	259	15
Net cash provided by financing activities	259	15
Net increase in cash and cash equivalents	314	2,871
CASH AND CASH EQUIVALENTS, beginning of period	59,656	88,867
CASH AND CASH EQUIVALENTS, end of period	$ 59,970	$ 91,738
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION:		
Interest paid	$ 18	$ --
Income taxes paid	$ 1,230	$ 4,330

</TABLE>

The accompanying notes are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(DOLLARS IN THOUSANDS, EXCEPT SHARE DATA)

1. ORGANIZATION

Centene Corporation (Centene or the Company) provides managed care programs and related services to individuals receiving benefits under Medicaid, including

Supplemental Security Income (SSI), and the State Children's Health Insurance Program (SCHIP). Centene operates under its own state licenses in Wisconsin, Texas, Indiana and New Jersey. In addition, the Company contracts with other health care organizations to provide specialty services including behavioral health, nurse triage and pharmacy compliance.

Centene's managed care organization subsidiaries include Managed Health Services Insurance Corp. (MHSIC), a wholly owned Wisconsin corporation; Superior Healthplan, Inc, (Superior), a wholly owned Texas corporation; Coordinated Care Corporation Indiana, Inc. (CCCI), a wholly owned Indiana corporation; and University Health Plans, Inc. (UHP), an 80% owned New Jersey corporation.

Centene's other subsidiaries include Centene Management Corporation (CMC), a wholly owned Wisconsin corporation; Bankers Reserve Life Insurance Company of Wisconsin (Bankers Reserve), a wholly owned Wisconsin corporation that the Company purchased on March 14, 2002; NurseWise, LP (NurseWise), a wholly owned Delaware corporation that was formed in August of 2002; Cenphiny, Inc. (Cenphiny), a wholly owned Delaware corporation that was incorporated in December of 2002; and Group Practice Affiliates, LLC (GPA), a 63.7% owned joint venture, purchased in March of 2003.

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, 2002. Accordingly, footnote disclosures, which would substantially duplicate the disclosures contained in the December 31, 2002 audited financial statements, have been omitted from these interim financial statements. 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.

3. RECENTLY ISSUED ACCOUNTING PRONOUNCEMENTS

In May 2002, SFAS No. 145, "Rescission of FASB Statements No. 4, 44, and 64, Amendment of FASB Statement No. 13, and Technical Corrections as of April 2002," was issued. As a result of the rescission of SFAS No. 4, gains and losses related to the extinguishment of debt should be classified as extraordinary only if they meet the criteria outlined under APB Opinion No. 30, "Reporting the Results of Operations - Reporting the Effects of Disposal of a Segment of a Business, and Extraordinary, Unusual and Infrequently Occurring Events and Transactions." SFAS No. 64, "Extinguishments of Debt Made to Satisfy Sinking-Fund Requirements," was an amendment to SFAS No. 4 and is no longer necessary. SFAS No. 44, "Accounting for Intangible Assets of Motor Carriers," defined accounting requirements for the effects of the transition to the Motor Carrier Act of 1980. The transitions are complete and SFAS No. 44 is no longer necessary. SFAS No. 145 amends SFAS No. 13, "Accounting for Leases," requiring that any capital lease that is modified resulting in an operating lease should be accounted for under the sale-leaseback provisions of SFAS No. 98 or SFAS No. 28, as applicable. SFAS No. 145 is effective for fiscal years beginning after May 15, 2002. The adoption of the provisions of SFAS No. 145 did not have a material impact on the Company's results of operations, financial position or cash flows.

In June 2002, SFAS No. 146, "Accounting for Costs Associated with Exit or Disposal Activities," was issued. It requires that a liability for a cost associated with an exit or disposal activity be recognized when the liability is incurred. This statement nullifies Emerging Issues Task Force Issue No. 94-3, "Liability Recognition for Certain Employee Termination Benefits and Other Costs to Exit an Activity (Including Certain Costs Incurred in a Restructuring)," which required that a liability for an exit cost be recognized upon the entity's commitment to an exit plan. SFAS No. 146 is effective for exit or disposal activities that are initiated after December 31, 2002. The adoption of the provisions of SFAS No. 146 did not have a material impact on the Company's results of operations, financial position or cash flows.

In December 2002, SFAS No. 148, "Accounting for Stock-Based Compensation - Transition and Disclosure," was issued. This statement amends FASB Statement No. 123, "Accounting for Stock-Based Compensation," to provide alternative methods of transition for an entity that voluntarily changes to the fair value based method of accounting for stock-based employee compensation. In addition, this statement amends the disclosure requirements of SFAS No. 123 and APB Opinion No.

28, "Interim Financial Reporting," to require prominent disclosures in both annual and interim financial statements about the method of accounting for stock-based employee compensation and the effect of the method used on reported results. SFAS No. 148 is effective for fiscal years ending after December 15, 2002 and for interim periods beginning after December 15, 2002. The adoption of the provisions of SFAS No. 148 did not have a material impact on the Company's results of operations, financial position or cash flows.

On January 17, 2003, FIN 46, "Consolidation of Variable Interest Entities, an Interpretation of ARB 51," was issued. The primary objectives of FIN 46 are to provide guidance on the identification and consolidation of variable interest entities, or VIEs, which are entities for which control is achieved through means other than through voting rights. The company has completed an analysis of FIN 46 and has determined that it does not have any VIEs.

4. RECLASSIFICATIONS

Certain 2002 amounts in the consolidated financial statements have been reclassified to conform to the 2003 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

5. STOCK OPTION PLANS

The Company accounts for stock-based compensation under Accounting Principles Board 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 income and earnings per share if the fair value based method had been applied to all awards.

<TABLE>
<CAPTION>

	THREE MONTHS ENDED MARCH 31,	
	2003	2002
<S>	<C>	<C>
Net earnings, as reported	$ 7,161	$ 4,300
Total stock-based employee compensation expense determined under fair value based method, net of related tax effects	855	204
Pro forma net earnings	$ 6,306	$ 4,096
Earnings per share:		
Basic, as reported	$ 0.66	$ 0.43
Basic, pro forma	0.58	0.41
Diluted, as reported	$ 0.60	$ 0.38
Diluted, pro forma	0.53	0.36
Shares used in computing per share amounts:		
Basic	10,898,849	10,091,348
Diluted	11,838,177	11,317,634

</TABLE>

The fair value of each option grant is estimated on the date of the grant using an option pricing model with the following assumptions: no dividend yield, expected volatility of 55% and 54%, risk-free interest rate of 3.3% and 3.6%, and expected lives of 7.3 and 7.4, for the three months ended March 31, 2003 and 2002, respectively.

(DOLLARS IN THOUSANDS, EXCEPT SHARE DATA)

6. EARNINGS PER SHARE

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

<TABLE>
<CAPTION>

	THREE MONTHS ENDED MARCH 31,	
	2003	2002
<S>	<C>	<C>
Net earnings	$ 7,161	$ 4,300
Shares used in computing per share amounts:		
Weighted average number of common shares outstanding	10,898,849	10,091,348
Dilutive effect of stock options (as determined by applying the treasury stock method)	939,328	1,226,286
Weighted average number of common shares and potential dilutive common shares outstanding	11,838,177	11,317,634
Earnings per common share, basic:		
Net earnings per common share	$ 0.66	$ 0.43
Earnings per common share, diluted:		
Net earnings per common share	$ 0.60	$ 0.38

</TABLE>

7. JOINT VENTURE - GROUP PRACTICE AFFILIATES

Effective March 1, 2003, Cenphiny, a wholly owned subsidiary of Centene, acquired a 63.7% ownership interest in Group Practice Affiliates, LLC. GPA, an Atlanta, Georgia-based behavioral healthcare services company, serves over 700,000 individuals in three states through a combination of networks, groups and schools, including Centene's Texas membership.

Cenphiny paid approximately $4,300 in cash for its investment in GPA. The cost to acquire the ownership interest has been preliminarily allocated to the assets acquired and liabilities assumed according to estimated fair values and is subject to adjustment when additional information concerning asset and liability valuations are finalized. The preliminary allocation has resulted in goodwill of approximately $1,795. The goodwill is not amortized and is not deductible for tax purposes.

The consolidated financial statements include the results of operations of GPA since March 1, 2003. In accordance with ARB No. 51, "Consolidated Financial Statements," the minority interests' share of GPA's deficit is shown as an additional component of goodwill of $469. In addition, Centene is recognizing 100% of GPA's earnings or losses subsequent to the date of investment until the historical partners' equity in GPA becomes positive.

Cenphiny may be required to make an additional investment, which is estimated not to exceed $1,700, in June 2004 based on GPA's 2003 performance and other factors. After a three-year term of the joint venture, Cenphiny will have the option to acquire the remaining interest in GPA. Similarly, the minority interest partners will have the option to sell their remaining interest in GPA to Cenphiny after the three-year term. Any purchase or sale of the remaining partners' interest will be equal to the fair market value of the partners' interests as of the date of the notice.

(DOLLARS IN THOUSANDS, EXCEPT SHARE DATA)

8. CONTRACT ACQUISITIONS

Effective March 1, 2003, Cenphiny purchased contract and name rights of ScriptAssist, LLC (ScriptAssist), a medication compliance company. ScriptAssist used various approaches and medical expertise to promote adherence to prescription drugs. Cenphiny is administering the purchased contracts under the ScriptAssist name.

Cenphiny paid approximately $561 in cash in connection with the purchase from ScriptAssist. Cenphiny allocated the entire purchase price of $561 to identifiable intangible assets, representing the value assigned to acquired contracts, which is being amortized on a straight-line basis over a period of five years, the expected period of benefit.

9. 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 maker to evaluate all results of operations.

With the acquisition of 63.7% of GPA and the purchase of ScriptAssist assets on March 1, 2003, Centene began operating 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 services including the reinsurance, behavioral health, nurse triage and pharmacy compliance functions.

Revenues and earnings from operations from third parties for the three months ended March 31, 2003, from Centene's Specialty Services segment represented less than 1.0% of the Company's consolidated revenues and earnings from operations. As a result, financial information by segment as of and for the three months ended March 31, 2003, has not been presented.

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 appearing elsewhere in this report and in our annual report for the year ended December 31, 2002. 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." 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.

OVERVIEW

We provide managed care programs and related services to individuals receiving benefits under Medicaid, including Supplemental Security Income, or SSI, and the State Children's Health Insurance Program, or SCHIP. We have health plans in Wisconsin, Texas, Indiana and New Jersey. In addition, we contract with other healthcare organizations to provide specialty services including behavioral health, nurse triage and pharmacy compliance.

Effective March 1, 2003, we acquired a 63.7% ownership interest in Group Practice Affiliates, or GPA. GPA, an Atlanta, Georgia-based behavioral healthcare services company, serves over 700,000 individuals in three states through a combination of networks, groups and schools, including our Texas membership of approximately 123,000. The joint venture investment is consistent with our strategy to provide diversified medical services to the managed Medicaid population.

We paid approximately $4.3 million in cash for our investment in GPA. We may be required to make an additional investment of up to $1.7 million in June 2004 based on GPA's 2003 performance and other factors. After a three-year term of the joint venture, we will have the option to acquire the remaining interest in GPA. Similarly the minority interest partners will have the option to sell their remaining interest in GPA to us after the three-year term. Any purchase or sale of the remaining partners' interest will be equal to the fair market value of the partners' interests as of the date of the notice.

Effective March 1, 2003, we purchased contract and name rights of ScriptAssist, a medication compliance company, for $561,000 in cash. ScriptAssist used various approaches and medical expertise to promote adherence to prescription drugs. We are administering the purchased contracts under the ScriptAssist name. The asset acquisition is consistent with our strategy to provide diversified medical services to the managed Medicaid population.

As a result of the ScriptAssist transaction, $561,000 was allocated to an intangible asset, purchased contract rights. We are amortizing the contract rights on a straight-line basis over five years, the period expected to be benefited.

On December 1, 2002, we acquired 80% of the outstanding capital stock of University Health Plans, or UHP, from University of Medicine and Dentistry of New Jersey, or UMDNJ, which continues to own the remaining capital stock of UHP. UHP is a managed health plan operating in 15 counties in New Jersey. We paid an aggregate purchase price of approximately $10.6 million for our interest in UHP. We entered into an investor rights agreement with UMDNJ providing that, among other things:

- We have the right, exercisable at any time prior to September 1, 2003, to purchase the remaining shares of UHP held by UMDNJ for a cash purchase price of $2.6 million.

- If we do not exercise the right described above, the remaining shares of UHP held by UMDNJ will be exchanged on December 1, 2005 for a purchase price payable in either, at our election, shares of our common stock or cash. The purchase price would equal the greater of (a) $2.6 million or (b) the product of (1) the enterprise value of UHP as of December 1, 2005 and (2) the percentage of the outstanding UHP common stock (on a fully diluted basis) then represented by the shares owned by UMDNJ.

In June 2002, Superior HealthPlan entered into an agreement with Texas Universities Health Plan Inc. to purchase the SCHIP contracts in three Texas service areas. Effective September 1, October 1 and November 1, 2002, the state of Texas approved the contract sales between Superior and Texas Universities Health Plan, thereby adding approximately 24,000 members to our Texas health plan. As a result of this transaction, $595,000 was recorded as an intangible asset, purchased contract rights. We are amortizing the contract rights on a straight-line basis over five years, the period expected to be benefited.

With our acquisition of 63.7% of GPA and our purchase of ScriptAssist assets, we began operating in two segments: Medicaid Managed Care and Specialty Services. The Medicaid Managed Care segment consists of our health plans, including all of the functions needed to operate them. The Specialty Services segment consists of our specialty services, including our reinsurance, behavioral health, nurse triage and pharmacy compliance functions. Our consolidated financial statements for the three months ended March 31, 2003 are not presented by segment because revenues and earnings from operations from third parties from our Specialty Services segment represented less than 1.0% of consolidated revenues and earnings from operations for such period.

REVENUES

We generate revenues 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. We generate services revenue for providing services on a non-risk basis to SSI members through our Medicaid managed care organizations, and for providing behavioral health, nurse triage and pharmacy compliance services to other healthcare entities.

The primary driver of our increasing revenues has been membership growth. We have increased our membership through internal growth and acquisitions. From March 31, 2002 to March 31, 2003, our membership grew 68.2%.

The following table depicts membership in our managed care organizations by state:

<TABLE>
<CAPTION>

	MARCH 31,	
	2003	2002
<S>	<C>	<C>
Wisconsin	139,100	114,600
Texas	122,700	57,100
Indiana	104,800	77,600
New Jersey	52,700	--
Total	419,300	249,300

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</TABLE>

The following table depicts membership in our managed care organizations by member category:

<TABLE>
<CAPTION>

	MARCH 31,	
	2003	2002
<S>	<C>	<C>
Medicaid (excluding SSI)	344,700	224,900
SCHIP	66,600	21,900
SSI	8,000	2,500
Total	419,300	249,300

</TABLE>

Our membership increased by 24,000 members in Texas due to the purchase of SCHIP contract rights from Texas Universities Health Plan through the third and fourth quarters of 2002. In addition, two smaller plans exited the Austin, Texas market during 2002. As a result, our Texas plan increased its membership by 28,000 lives. This increase includes 12,000 lives that we are managing for the state of Texas on an interim basis and that will become part of a reprocurement process scheduled for mid 2003. We entered the New Jersey market through our acquisition of 80% of the equity of UHP in December 2002. The remaining membership increases in our Wisconsin, Texas and Indiana markets resulted from additions to our provider network and growth in the number of Medicaid beneficiaries.

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. 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 physician billing patterns, membership, products and inpatient hospital trends. These estimates are adjusted as more information becomes available. We utilize the services of independent actuarial consultants 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 exceed 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 ratio by member category:

<TABLE>
<CAPTION>

	THREE MONTHS ENDED MARCH 31,	
	2003	2002
<S>	<C>	<C>
Medicaid (excluding SSI)	82.4%	82.5%
SSI	104.2%	--
Total	83.4%	82.5%

</TABLE>

While our core Medicaid business remained consistent between periods, the addition of the SSI members in New Jersey in December of 2002 has caused our health benefits ratio to increase. The health benefits ratio for SSI is affected by a low membership base, which subjects us to volatility. We expect the health benefits ratio for SSI to decrease as these members become fully integrated into

our medical management programs and our membership base grows within the state of New Jersey as well as in new markets.

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 and our centralized functions that support all of our business units. The major centralized functions are claims processing, information systems, finance, medical management support, human resources and administration. 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. Although we did not operate a Specialty Services segment in the prior year, prior year ratios have been presented for comparison purposes.

<TABLE>
<CAPTION>

	THREE MONTHS ENDED MARCH 31,	
	2003	2002
<S>	<C>	<C>
Medicaid Managed Care	10.5%	10.7%
Specialty Services	18.6%	20.1%
Total	10.9%	10.9%

</TABLE>

OTHER INCOME (EXPENSE)

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

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

- Interest expense primarily reflects the non-use fee on our revolving credit facility.

RESULTS OF OPERATIONS

THREE MONTHS ENDED MARCH 31, 2003 COMPARED TO THREE MONTHS ENDED MARCH 31, 2002

Revenues

Premiums for the three months ended March 31, 2003 increased $80.6 million, or 84.2%, to $176.2 million from $95.7 million for the comparable period in 2002. This increase was due to organic growth in our existing markets, changes in our member mix, the purchase of the Texas SCHIP contracts and the acquisition of 80% of the outstanding capital stock of UHP. In addition, we received weighted average rate increases effective January 1, 2003, of 1.0% in Indiana and 4.3% in Wisconsin.

Services revenue for the three months ended March 31, 2003 increased $1.1 million to $1.2 million from $103,000 for the comparable period in 2002. This increase resulted from increases in our non-risk SSI membership in our Texas market and from the inclusion of one month of services revenue of GPA.

Operating Expenses

Medical costs for the three months ended March 31, 2003 increased $68.0 million, or 86.1%, to $146.9 million from $78.9 million for the comparable period in 2002. This increase primarily reflected the growth in our membership as described above.

Cost of services for the three months ended March 31, 2003 increased $893,000, or 1089%, to $975,000 from $82,000 for the comparable period in 2002. This increase was due to the inclusion of one month of direct costs related to the services revenue of GPA.

General and administrative expenses for the three months ended March 31, 2003 increased $8.9 million, or 85.4%, to $19.4 million from $10.5 million for the comparable period in 2002. This increase reflected a higher level of

wages and related expenses for additional staff to support our membership growth and expanding markets.

Other Income (Expense)

Other income (expense) for the three months ended March 31, 2003 increased $32,000, or 3.5%, to $947,000 from $915,000 for the comparable period in 2002. The modest increase between periods is due to a larger amount of dollars invested offset by the decrease in the interest rate environment.

Income Tax Expense

For the three months ended March 31, 2003, we recorded income tax expense of $4.2 million based on a 38.2% effective tax rate. For the three months ended March 31, 2002, we recorded income tax expense of $2.9 million based on an effective tax rate of 40.1%. Our effective tax rate decreased period over period due to our investment in tax-advantaged securities and our implementation of state tax savings strategies during the three months ended September 30, 2002.

LIQUIDITY AND CAPITAL RESOURCES

Our operating activities provided cash of $9.9 million for the three months ended March 31, 2003 compared to $2.3 million for the three months ended March 31, 2002. The increase in cash provided in the three months ended March 31, 2003 compared to the three months ended March 31, 2002 is due to continued profitability, an increase in membership and timing of income tax payments.

Our investing activities used cash of $9.8 million for the three months ended March 31, 2003 and provided cash of $552,000 for the comparable period in 2002. 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 March 31, 2003, our investment portfolio consisted primarily of fixed-income securities with an average duration of 2.9 years. Cash is invested in investment vehicles such as municipal bonds, commercial paper, U.S. government-backed agencies and U.S. Treasury instruments. The states in which we operate prescribe the types of instruments in which our subsidiaries may invest their cash. The average annualized portfolio yield was 3.5% for the three months ended March 31, 2003 and 6.9% for the year ended December 31, 2002, exclusive of a one-time dividend of $5.1 million from a captive insurance company in which we maintained an investment. Our yield decreased due to our investment in tax-advantaged securities in the third and fourth quarters of 2002 as well as a decrease in the overall interest rate environment.

Our financing activities provided cash of $259,000 for the three months ended March 31, 2003 and $15,000 for the three months ended March 31, 2002. Cash flows for these periods consisted of proceeds received from the exercise of stock options.

We may use our existing funds to make strategic acquisitions including Medicaid and SCHIP businesses, specialty services businesses and contract rights to increase our membership and to expand our business into new service areas. For example, effective March 1, 2003, we acquired a 63.7% interest in GPA

for $4.3 million and purchased assets of ScriptAssist for $561,000.

Our capital expenditures consist primarily of new software, software and hardware upgrades, and furniture, equipment and leasehold improvements related to office and market expansions. We purchased $684,000 of capital assets during the three months ended March 31, 2003, and we anticipate spending $6.6 million for additional capital expenditures during the remainder of 2003 on office and market expansions and system upgrades. In addition, we are investigating opportunities to purchase our corporate headquarters to eliminate potential disruptions to our business. This is not expected to significantly affect our cash flows or cash position.

Our principal contractual obligations at March 31, 2003 consisted of obligations under operating leases. The significant annual noncancelable lease payments over the next five years and beyond are as follows (in thousands):

<TABLE>
<CAPTION>

	PAYMENTS DUE
<S>	<C>
March 31 through December 31, 2003	$ 4,286
2004	5,495
2005	5,012

2006	4,453
2007	3,847
Thereafter	8,065
Total	$ 31,158

</TABLE>

At March 31, 2003, we had working capital, defined as current assets less current liabilities, of $(12.4) million as compared to $(8.8) million at December 31, 2002. Our working capital is often minimal and sometimes negative due to our efforts to increase investment returns through purchases of long-term investments, which 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 working capital as needed.

Cash, cash equivalents and short-term investments were $68.7 million at March 31, 2003 and $69.2 million at December 31, 2002. Long-term investments were $103.7 million at March 31, 2003 and $95.4 million at December 31, 2002 including restricted deposits of $16.5 million and $15.8 million, respectively. Cash and investments held by our unregulated entities totaled $46.4 million at March 31, 2003. 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 and capital expenditures for at least 12 months from the date of this report.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

Our operations are conducted through our subsidiaries. As managed care organizations, our subsidiaries are subject to state regulations that, among other things, may 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 March 31, 2003, our subsidiaries had aggregate statutory capital and surplus of $42.9 million, compared with the required minimum aggregate statutory capital and surplus requirements of $23.4 million.

The National Association of Insurance Commissioners adopted guidelines which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. Wisconsin and Texas adopted various forms of the rules as of December 31, 1999. As of December 31, 2002 our Wisconsin and Texas health plans were in compliance with risk-based capital requirements. The managed care organization rules, if adopted by Indiana and New Jersey, may increase the minimum capital required for our health plans in these states. We continue to monitor these requirements and do not expect that they will have a material impact on our results of operations, financial position or cash flows.

RECENT ACCOUNTING PRONOUNCEMENTS

In May 2002, SFAS No. 145, "Rescission of FASB Statements No. 4, 44, and 64, Amendment of FASB Statement No. 13, and Technical Corrections as of April 2002," was issued. As a result of the rescission of SFAS No. 4, gains and losses related to the extinguishment of debt should be classified as extraordinary only if they meet the criteria outlined under APB Opinion No. 30, "Reporting the Results of Operations - Reporting the Effects of Disposal of a Segment of a Business, and Extraordinary, Unusual and Infrequently Occurring Events and Transactions." SFAS No. 64, "Extinguishments of Debt Made to Satisfy Sinking-Fund Requirements," was an amendment to SFAS No. 4 and is no longer necessary. SFAS No. 44, "Accounting for Intangible Assets of Motor Carriers," defined accounting requirements for the effects of the transition to the Motor Carrier Act of 1980. The transitions are complete and SFAS No. 44 is no longer necessary. SFAS No. 145 amends SFAS No. 13, "Accounting for Leases," requiring that any capital lease that is modified resulting in an operating lease should be accounted for under the sale-leaseback provisions of SFAS No. 98 or SFAS No. 28, as applicable. SFAS No. 145 is effective for fiscal years beginning after May 15, 2002. The adoption of the provisions of SFAS No. 145 did not have a material impact on our results of operations, financial position or cash flows.

In June 2002, SFAS No. 146, "Accounting for Costs Associated with Exit or Disposal Activities," was issued. It requires that a liability for a cost associated with an exit or disposal activity be recognized when the liability is incurred. This statement nullifies Emerging Issues Task Force Issue No. 94-3, "Liability Recognition for Certain Employee Termination Benefits and Other Costs

to Exit an Activity (Including Certain Costs Incurred in a Restructuring)," which required that a liability for an exit cost be recognized upon the entity's commitment to an exit plan. SFAS No. 146 is effective for exit or disposal activities that are initiated after December 31, 2002. The adoption of the provisions of SFAS No. 146 did not have a material impact on our results of operations, financial position or cash flows.

In December 2002, SFAS No. 148, "Accounting for Stock-Based Compensation - Transition and Disclosure," was issued. This statement amends FASB Statement No. 123, "Accounting for Stock-Based Compensation," to provide alternative methods of transition for an entity that voluntarily changes to the fair value based method of accounting for stock-based employee compensation. In addition, this statement amends the disclosure requirements of SFAS No. 123 and APB Opinion No. 28, "Interim Financial Reporting," to require prominent disclosures in both annual and interim financial statements about the method of accounting for stock-based employee compensation and the effect of the method used on reported results. SFAS No. 148 is effective for fiscal years ending after December 15, 2002 and for interim periods beginning after December 15, 2002. The adoption of the provisions of SFAS No. 148 did not have a material impact on our results of operations, financial position or cash flows.

On January 17, 2003, FIN 46, "Consolidation of Variable Interest Entities, an Interpretation of ARB 51," was issued. The primary objectives of FIN 46 are to provide guidance on the identification and consolidation of variable interest entities, which are entities for which control is achieved through means other than through voting rights. Our management has completed an analysis of FIN 46 and has determined that we do not have any variable interest entities.

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 report, including our consolidated financial statements and related notes. 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

Reductions in Medicaid Funding Could Substantially Reduce Our Profitability.

Nearly all of our revenues come from Medicaid 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 premium rates may be affected by continued government efforts to contain medical costs and may further be affected by state and federal

budgetary constraints. Changes to Medicaid 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. We believe that reductions in Medicaid 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 Medicaid, including 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 June 30, 2003 and December 31, 2003. Our contracts with the states of Indiana and Wisconsin accounted for 73% of our revenues for the year ended December 31, 2002. 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 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.

For example, Congress recently has considered various forms of patient protection legislation commonly known as Patients' Bills of Rights. We cannot predict the impact of this legislation, if adopted, on our business.

Regulations May Decrease the Profitability of Our Health Plans.

Our Texas plans are required to pay a rebate to the state in the event profits exceed established levels. To date no rebates have been required. This regulatory requirement, changes in this requirement 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 state of Texas has implemented this requirement and is enforcing a penalty provision for failure to pay claims in a timely manner. Failure to meet this requirement 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, the federal Centers for Medicare and Medicaid Services, or CMS, published a final rule that removed an exception 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 percent of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicaid payment principles. This development in federal law could decrease 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. Because of these potential sanctions, we seek to monitor our compliance and that of our providers with federal and state fraud and abuse and other healthcare laws on an ongoing basis. These penalties or exclusions were they to occur as the result of our actions or omissions, or our inability to monitor the compliance of our providers, would negatively impact 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, including a whistle blower program.

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 individually identifiable health information. Congress may enact additional legislation to increase penalties and to create a private right of action under HIPAA, which would entitle patients to seek monetary damages for violations of the privacy rules.

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

In August 2000, HHS issued a new regulation under HIPAA requiring the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. We are required to comply with the new regulation by October 2003. In December 2000, HHS issued a new regulation mandating heightened privacy and confidentiality protections under HIPAA that became effective on April 14, 2001. Compliance with this regulation was required by April 14, 2003. We are in compliance with this regulation. On February 20, 2003 HHS published the final HIPAA security regulations. The security regulations became effective on April 21, 2003. Compliance with the security regulations will be 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 Bush Administration's issuance of new regulations and its review of existing regulations, the states' ability to promulgate stricter rules, and uncertainty regarding many aspects of the regulations may make compliance with the relatively new regulatory landscape difficult. 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 are not expected to exceed $500,000 in 2003. 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. The new regulations and the related compliance costs could have a material adverse effect on our business.

Changes in Federal Funding Mechanisms May Reduce Our Profitability.

In February 2003, 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 combined Medicaid-SCHIP "allotments" for acute and long-term health care 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 the initial proposal. 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.

If We Are Unable to Participate in SCHIP Programs Our Growth Rate May Be Limited.

SCHIP is a relatively new 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.

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 customers. If premiums do not increase when expenses related to medical services rise, our earnings would 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 83.4% for the three months ended March 31, 2003, 82.3% for 2002, 82.8% for 2001 and 84.3% for 2000, 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. For example, our acquisition of 80% of the equity of UHP on December 1, 2002, accounted for 30.3% of the increase in our membership for the year ended December 31, 2002 compared to 2001. 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 (1) selling, along with their Medicaid assets, other assets in which we do not have an interest or (2) 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;

- existing provider networks, which 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.

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. In addition, we may not be able to effectively commercialize any new programs or services we seek to market to third parties. 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 All of Our Premium Revenues from Operations in Four States, and Our Operating Results Would be Materially Affected by a Decrease in Revenues or Profitability in Any One of Those States.

Operations in Wisconsin, Texas, Indiana and New Jersey account for most of our revenues. 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 would decrease materially. In the first half of 2001, our membership in Indiana declined by approximately 46,000 due to a subcontracting provider organization terminating a percent-of-premium arrangement. 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 industries. 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.

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. 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 Medicaid managed care 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 mission 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 industry with the breadth of skills and experience required to operate and expand successfully 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.

Recently, 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.

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. In particular, the terrorist acts of September 11, 2001 created an uncertain economic environment that has continued to date, and we cannot predict the impact of these events, other acts of terrorism or related military action on federal or state funding of healthcare programs or on the size of the Medicaid-eligible population. If federal funding were decreased or unchanged while our membership was increasing, our results of operations would 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 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 business 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.

We May Not Be Able to Obtain and 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.

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK.

Investments

As of March 31, 2003, we had short-term investments of $8.7 million and long-term investments of $103.7 million, including restricted deposits of $16.5 million. The short-term investments consisted of highly liquid securities with maturities between three and twelve months. The long-term investments consisted of municipal bonds, U.S. agencies and U.S. Treasury investments, and had original maturities greater than one year. Restricted deposits consisted of investments required by various state statutes to be deposited or pledged to state agencies. These investments are classified as long-term regardless of the contractual maturity date due to the nature of the states' requirements. These

investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold the short-term investments to maturity, and as a result, we would not expect the value of these investments to decline significantly as a result of a sudden change in market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at March 31, 2003, the fair value of our fixed income investments would have decreased by $2.5 million. Similarly, a 1% decrease in market interest rates at March 31, 2003 would have resulted in an increase of the fair value of our investments of $2.5 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 2003. 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.

Evaluation of disclosure controls and procedures. Based on their evaluations as of a date within 90 days of the filing date of this report, our principal executive officer and principal financial officer, with the participation of our full management team, have concluded that our disclosure controls and procedures (as defined in Rules 13a-14(c) and 15d-14(c) under the Securities Exchange Act) are effective to ensure that information required to be disclosed by us in reports that we file or submit under the Securities Exchange Act is recorded, processed, summarized and reported within the time periods specified in the rules and forms of the SEC.

Changes in internal controls. There were no significant changes in our internal controls or in other factors that could significantly affect these internal controls subsequent to the date of their most recent evaluation, including any corrective actions with regard to significant deficiencies and material weaknesses.

PART II

OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS.

None.

ITEM 2. CHANGES IN 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.

ITEM 6. EXHIBITS AND REPORTS ON FORM 8-K.

(a) Exhibits.

<TABLE>
<CAPTION>

EXHIBIT NUMBER	DESCRIPTION
<S>	<C>
99.1	Certification Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

</TABLE>

(b) Reports on Form 8-K.

None.

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 April 30, 2003.

CENTENE CORPORATION

By: /s/ Michael F. Neidorff

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

By: /s/ Karey L. Witty

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

CERTIFICATIONS

I, Michael F. Neidorff, certify that:

1. I have reviewed this quarterly report on Form 10-Q of Centene Corporation;

2. based on my knowledge, this quarterly report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the periods covered by this quarterly report;

3. based on my knowledge, the financial statements, and other financial information included in this quarterly report, fairly present in all material respects the financial condition, results of operations and cash flows of Centene Corporation as of, and for, the periods presented in this quarterly report;

4. Karey L. Witty, the Senior Vice President, Chief Financial Officer and Treasurer of Centene Corporation, and I:

- are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules, Rule 13a-14 and 15d-14) for Centene Corporation;

- have designed such disclosure controls and procedures to ensure that material information relating to Centene Corporation, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this quarterly report was prepared;

- have evaluated the effectiveness of the disclosure controls and procedures of Centene Corporation as of a date within 90

days prior to the filing date of this quarterly report; and

- have presented in this quarterly report our conclusions about the effectiveness of the disclosure controls and procedures based on the required evaluation as of that date;

5. Mr. Witty and I have disclosed, based on our most recent evaluation, to the auditors of Centene Corporation and to the audit committee of the board of directors of Centene Corporation:

- all significant deficiencies in the design or operation of internal controls that could adversely affect the ability of Centene Corporation to record, process, summarize and report financial data and have identified for such auditors any material weaknesses in internal controls; and

- any fraud, whether or not material, that involves management or other employees who have a significant role in the internal controls of Centene Corporation; and

6. Mr. Witty and I have indicated in this quarterly report whether or not there were significant changes in internal controls or in other factors that could significantly affect internal controls subsequent to the date of their evaluation, including any corrective actions with regard to significant deficiencies and material weaknesses.

Date: April 30, 2003

/s/ Michael F. Neidorff

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

I, Karey L. Witty, certify that:

1. I have reviewed this quarterly report on Form 10-Q of Centene Corporation;

2. based on my knowledge, this quarterly report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the periods covered by this quarterly report;

3. based on my knowledge, the financial statements, and other financial information included in this quarterly report, fairly present in all material respects the financial condition, results of operations and cash flows of Centene Corporation as of, and for, the periods presented in this quarterly report;

4. Michael F. Neidorff, the President and Chief Executive Officer of Centene Corporation, and I:

- are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules, Rule 13a-14 and 15d-14) for Centene Corporation;

- have designed such disclosure controls and procedures to ensure that material information relating to Centene Corporation, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this quarterly report was prepared;

- have evaluated the effectiveness of the disclosure controls and procedures of Centene Corporation as of a date within 90 days prior to the filing date of this quarterly report; and

- have presented in this quarterly report our conclusions about the effectiveness of the disclosure controls and procedures based on the required evaluation as of that date;

5. Mr. Neidorff and I have disclosed, based on our most recent evaluation, to the auditors of Centene Corporation and to the audit committee of the board of directors of Centene Corporation:

- all significant deficiencies in the design or operation of internal controls that could adversely affect the ability of Centene Corporation to record, process, summarize and report financial data and have identified for such auditors any material weaknesses in internal controls; and

- any fraud, whether or not material, that involves management or other employees who have a significant role in the internal controls of Centene Corporation; and

6. Mr. Neidorff and I have indicated in this quarterly report whether or not there were significant changes in internal controls or in other factors that could significantly affect internal controls subsequent to the date of our evaluation, including any corrective actions with regard to significant deficiencies and material weaknesses.

Date: April 30, 2003

/s/ Karey L. Witty

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

EXHIBIT 99.1

CERTIFICATE PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the quarterly report on Form 10-Q of Centene Corporation (the Company) for the period ended March 31, 2003, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Michael F. Neidorff, President and Chief Executive Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

1. the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities and Exchange Act of 1934; and

2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

A signed original of this written statement required by Section 906 has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request.

/s/ Michael F. Neidorff

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

Dated: April 30, 2003

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the quarterly report on Form 10-Q of Centene Corporation (the Company) for the period ended March 31, 2003, as filed with the Securities and Exchange Commission of the date hereof (the Report), the undersigned, Karey L. Witty, Senior Vice President, Chief Financial Officer and Treasurer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

1. the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities and Exchange Act of 1934; and

2. the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

A signed original of this written statement required by Section 906 has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request.

/s/ Karey L. Witty

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

Dated: April 30. 2003