SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

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

For the quarterly period ended September 30, 2006

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 *(State or other jurisdiction of incorporation or organization)*	**42-1406317** *(I.R.S. Employer Identification Number)*
7711 Carondelet Avenue, Suite 800 **St. Louis, Missouri** *(Address of principal executive offices)*	**63105** *(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: ☑ Yes ☐ No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☑ Accelerated filer ☐ Non-accelerated filer ☐

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

As of October 16, 2006, the registrant had 43,168,018 shares of common stock outstanding.

CENTENE CORPORATION

QUARTERLY REPORT ON FORM 10-Q

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PART I

FINANCIAL INFORMATION

ITEM 1. ***Financial Statements.***

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS
(In thousands, except share data)

	September 30, 2006	December 31, 2005
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 200,480	$ 147,358
Premium and related receivables, net of allowances of $125 and $343, respectively	86,108	44,108
Short-term investments, at fair value (amortized cost $67,679 and $56,863, respectively)	67,392	56,700
Other current assets	20,776	24,439
Total current assets	374,756	272,605
Long-term investments, at fair value (amortized cost $148,415 and $126,039, respectively)	146,666	123,661
Restricted deposits, at fair value (amortized cost $25,691 and $22,821, respectively)	25,565	22,555
Property, software and equipment, net	103,175	67,199
Goodwill	136,519	157,278
Other intangible assets, net	14,949	17,368
Other assets	12,211	7,364
Total assets	$ 813,841	$ 668,030
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liabilities	$ 246,669	$ 170,514
Accounts payable and accrued expenses	67,957	29,790
Unearned revenue	18,597	13,648
Current portion of long-term debt and notes payable	1,032	699
Total current liabilities	334,255	214,651
Long-term debt	168,429	92,448
Other liabilities	5,252	8,883
Total liabilities	507,936	315,982
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; issued and outstanding 43,168,505 and 42,988,230 shares, respectively	44	43
Additional paid-in capital	202,760	191,840
Accumulated other comprehensive income:		
Unrealized loss on investments, net of tax	(1,356)	(1,754)
Retained earnings	104,457	161,919
Total stockholders' equity	305,905	352,048
Total liabilities and stockholders' equity	$ 813,841	$ 668,030

See notes to consolidated financial statements.

CENTENE CORPORATION AND SUBSIDIARIES

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2006	2005	2006	2005
	(Unaudited)		(Unaudited)	
Revenues:				
Premium	$ 610,661	$ 395,667	$ 1,522,302	$ 1,075,027
Service	20,588	4,975	59,318	7,619
Total revenues	631,249	400,642	1,581,620	1,082,646
Expenses:				
Medical costs	501,350	331,050	1,263,251	881,021
Cost of services	15,373	2,002	45,278	3,573
General and administrative expenses	93,991	52,450	233,654	139,274
Impairment loss	87,091	—	87,091	—
Total operating expenses	697,805	385,502	1,629,274	1,023,868
Earnings (loss) from operations	(66,556)	15,140	(47,654)	58,778
Other income (expense):				
Investment and other income	4,625	2,818	12,056	7,461
Interest expense	(3,082)	(1,190)	(7,536)	(2,386)
Earnings (loss) before income taxes	(65,013)	16,768	(43,134)	63,853
Income tax expense	6,180	4,662	14,328	22,087
Net earnings (loss)	$ (71,193)	$ 12,106	$ (57,462)	$ 41,766
Earnings (loss) per share:				
Basic earnings (loss) per common share	$ (1.65)	$ 0.28	$ (1.33)	$ 0.99
Diluted earnings (loss) per common share	$ (1.65)	$ 0.27	$ (1.33)	$ 0.93
Weighted average number of shares outstanding:				
Basic	43,219,053	42,582,129	43,126,062	42,120,149
Diluted	43,219,053	45,278,328	43,126,062	45,078,852

See notes to consolidated financial statements.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)

	Nine Months Ended September 30,	
	2006	2005
	(Unaudited)	
Cash flows from operating activities:		
Net earnings (loss)	$ (57,462)	$ 41,766
Adjustments to reconcile net earnings (loss) to net cash provided by operating activities —		
Depreciation and amortization	15,286	9,658
Excess tax benefits from stock compensation	—	4,511
Stock compensation expense	11,168	3,557
Impairment loss	87,091	—
Loss on sale of investments	33	58
Deferred income taxes	(4,493)	(3,567)
Changes in assets and liabilities —		
Premium and related receivables	(34,209)	(9,396)
Other current assets	2,705	(1,990)
Other assets	(455)	(1,380)
Medical claims liabilities	74,367	(17,091)
Unearned revenue	4,816	5,892
Accounts payable and accrued expenses	25,929	11,798
Other operating activities	(221)	1,096
Net cash provided by operating activities	124,555	44,912
Cash flows from investing activities:		
Purchase of property, software and equipment	(39,494)	(16,837)
Purchase of investments	(235,501)	(108,630)
Sales and maturities of investments	200,155	129,095
Acquisitions, net of cash acquired	(66,921)	(55,410)
Net cash used in investing activities	(141,761)	(51,782)
Cash flows from financing activities:		
Proceeds from exercise of stock options	4,594	3,925
Proceeds from borrowings	83,359	45,000
Payment of long-term debt and notes payable	(12,505)	(4,323)
Excess tax benefits from stock compensation	2,094	—
Common stock repurchases	(7,214)	—
Other financing activities	—	(413)
Net cash provided by financing activities	70,328	44,189
Net increase in cash and cash equivalents	53,122	37,319
Cash and cash equivalents, beginning of period	147,358	84,105
Cash and cash equivalents, end of period	$ 200,480	$ 121,424
Interest paid	$ 7,582	$ 2,184
Income taxes paid	$ 5,223	$ 19,658
Supplemental schedule of non-cash financing activities:		
Common stock issued for acquisitions	$ —	$ 8,991

See notes to consolidated financial statements.

CENTENE CORPORATION AND SUBSIDIARIES

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

1. Organization

Centene Corporation (Centene or the Company) is a multi-line healthcare enterprise operating primarily in two segments. The government services Medicaid Managed Care segment provides Medicaid and Medicaid-related programs to organizations and individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program (SCHIP) and Supplemental Security Income (SSI) . The Specialty Services segment provides specialty services, including behavioral health, disease management, managed vision, nurse triage, pharmacy benefits management and treatment compliance, to Centene companies, state programs, commercial organizations and other healthcare organizations. The Company, through long-term care programs, also serves individuals who are dually eligible under Medicaid and Medicare.

2. Basis of Presentation

The unaudited interim financial statements herein have been prepared by the Company pursuant to the rules and regulations of the Securities and Exchange Commission. The accompanying interim financial statements have been prepared under the presumption that users of the interim financial information have either read or have access to the audited financial statements for the fiscal year ended December 31, 2005. Accordingly, footnote disclosures, which would substantially duplicate the disclosures contained in the December 31, 2005 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 2005 amounts in the consolidated financial statements have been reclassified to conform to the 2006 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

3. Recent Accounting Pronouncements

In July 2006, the Financial Accounting Standards Board (FASB) issued Interpretation 48 (FIN 48), "Accounting for Uncertainty in Income Taxes," an interpretation of FASB Statement No. 109, "Accounting for Income Taxes." FIN 48 clarifies the accounting for uncertainty in income taxes recognized in an enterprise's financial statements in accordance with FASB Statement No. 109. FIN 48 describes a recognition threshold and measurement attribute for financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return and also provides guidance on derecognition, classification, interest and penalties, accounting in interim periods, disclosure and transition. The Interpretation is effective for fiscal years beginning after December 15, 2006. The Company is currently assessing the estimated effect of FIN 48 on the financial condition and results of operations upon adoption on January 1, 2007.

4. Stock Incentive Plans

In December 2004, the FASB issued Statement of Financial Accounting Standards No. 123 (revised 2004), "Share Based Payment," (SFAS 123R). SFAS 123R establishes the accounting for transactions in which an entity pays for employee services in share-based payment transactions. SFAS 123R requires companies to measure the cost of employee services received in exchange for an award of equity instruments based on the grant-date fair value of the award. The fair value of employee share options and similar instruments is estimated using option-pricing models adjusted for the unique characteristics of those instruments. That cost is recognized over the period during which an employee is required to provide service in exchange for the award. The Company adopted SFAS 123R effective January 1, 2006, using the modified-prospective transition method. Under this method, compensation cost is recognized for awards granted and for awards modified, repurchased or cancelled in the period after adoption. Compensation cost is also recognized for the unvested portion of awards granted prior to adoption. Prior year financial statements are not restated. The Company's results for the three and nine months ended September 30, 2006 reflected the following changes as a result of adopting SFAS 123R:

	Three Months Ended September 30, 2006	Nine Months Ended September 30, 2006
General and administrative expenses	$ 2,664	$ 7,566
Net earnings	$ (2,454)	$ (5,891)
Basic earnings per common share	$ (0.06)	$ (0.14)
Diluted earnings per common share	$ (0.06)	$ (0.14)

Additionally, upon adoption of SFAS 123R, excess tax benefits related to stock compensation are presented as a cash inflow from financing activities. This change had the effect of decreasing cash flows from operating activities and increasing cash flows from financing activities by $117 and $2,094 in the three and nine months ended September 30, 2006, respectively.

For the nine months ended September 30, 2005, the Company accounted for stock-based compensation plans under APB Opinion No. 25, "Accounting for Stock Issued to Employees." Compensation cost related to stock options issued to employees was recorded only if the grant-date market price of the underlying stock exceeded the exercise price. The following table illustrates the effect on net earnings and earnings per share if a fair value-based method had been applied to all awards.

	Three Months Ended September 30, 2005	Nine Months Ended September 30, 2005
Net earnings	$ 12,106	$ 41,766
Stock-based employee compensation expense included in net earnings, net of related tax effects	777	2,206
Stock-based employee compensation expense determined under fair value based method, net of related tax effects	(2,003)	(6,035)
Pro forma net earnings	$ 10,880	$ 37,937
Basic earnings per common share:		
As reported	$ 0.28	$ 0.99
Pro forma	$ 0.26	$ 0.90
Diluted earnings per common share:		
As reported	$ 0.27	$ 0.93
Pro forma	$ 0.24	$ 0.85

The Company's stock incentive plans allow for the granting of restricted stock or restricted stock unit awards and options to purchase common stock. Both incentive stock options and nonqualified stock options can be awarded under the plans. No option will be exercisable for longer than ten years after the date of grant. The plans have 876,679 shares available for future awards. Compensation expense for stock options and restricted stock unit awards is recognized on a straight-line basis over the vesting period, generally three to five years for stock options and one to ten years for restricted stock or restricted stock unit awards. Certain awards provide for accelerated vesting if there is a change in control as defined in the plans.

Option activity for the nine months ended September 30, 2006 is summarized below:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value	Weighted Average Remaining Contractual Term
Outstanding as of December 31, 2005	5,273,571	$ 15.79		
Granted	94,500	26.11		
Exercised	(497,768)	7.94		
Expired	(25,500)	23.83		
Forfeited	(198,000)	18.20		
Outstanding as of September 30, 2006	4,646,803	$ 16.70	$ 14,894	7.2
Exercisable as of September 30, 2006	2,125,445	$ 13.10	$ 11,183	6.3

The fair value of each option grant is estimated on the date of the grant using the Black-Scholes option-pricing model with the following assumptions:

	Nine Months Ended September 30,	
	2006	2005
Expected life (in years)	6.5	6.0
Risk-free interest rate	4.7%	4.0%
Expected volatility	44.2%	54.1%
Expected dividend yield	0%	0%

For the nine months ended September 30, 2006, the expected life of each award granted was calculated using the “simplified method” in accordance with Staff Accounting Bulletin No. 107. For the nine months ended September 30, 2005, the Company used a projected expected life for each award granted based on historical experience of employees’ exercise behavior. For the nine months ended September 30, 2006, expected volatility is primarily based on historical volatility levels along with the implied volatility of exchange traded options to purchase Centene common stock. For the nine months ended September 30, 2005, expected volatility is based on historical volatility levels. The risk-free interest rate is based on the implied yield currently available on U.S. Treasury zero coupon issues with a remaining term equal to the expected life.

Other information pertaining to option activity during the three and nine months ended September 30, 2006 and 2005 was as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2006	2005	2006	2005
Weighted-average fair value of options granted	$ 8.52	$ 17.63	$ 13.36	$ 17.61
Total intrinsic value of stock options exercised	$ 1,567	$ 3,723	$ 7,607	$ 27,533

Non-vested restricted stock and restricted stock unit activity for the nine months ended September 30, 2006 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Non-vested balance as of December 31, 2005	1,153,655	$ 25.20
Granted	46,490	27.59
Vested	(27,189)	31.32
Forfeited	(3,400)	25.50
Non-vested balance as of September 30, 2006	1,169,556	$ 25.16

As of September 30, 2006, there was $44,152 of total unrecognized compensation cost related to non-vested share-based compensation arrangements granted under the plans; that cost is expected to be recognized over a weighted-average period of four years.

5. Acquisitions

US Script

Effective January 1, 2006, the Company acquired 100% of US Script, Inc., a pharmacy benefits manager. The Company paid approximately $40,600 in cash and related transaction costs. In accordance with the terms of the agreement, the Company may pay up to an additional $10,000 if US Script, Inc. achieves certain earnings targets over a five-year period. The results of operations for US Script, Inc. are included in the consolidated financial statements since January 1, 2006.

The preliminary purchase price allocation resulted in estimated identifiable intangible assets of $5,000 and associated deferred tax liabilities of $2,000 and goodwill of approximately $36,900. The identifiable intangible assets have an estimated useful life of five years. The acquired goodwill is not deductible for income tax purposes. Pro forma disclosures related to the acquisition have been excluded as immaterial.

AirLogix

Effective July 22, 2005, the Company acquired 100% of AirLogix, Inc., a disease management provider. The Company paid approximately $36,310 in cash and related transaction costs. The results of operations for AirLogix, Inc. are included in the consolidated financial statements since July 22, 2005.

The purchase price allocation resulted in estimated identified intangible assets of $2,550 and associated deferred tax liabilities of $997 and goodwill of $28,727. The identifiable intangible assets have an estimated useful life of one to five years. The acquired goodwill is not deductible for income tax purposes. Pro forma disclosures related to the acquisition have been excluded as immaterial.

Other

The Company acquired Opticare Managed Vision, Inc., effective July 1, 2006, MediPlan Corporation, effective June 1, 2006, Cardium Health Services Corporation, effective May 9, 2006, and Health Dimensions of Florida, Inc., effective April 1, 2006. The Company paid a total of $30,800 in cash and related transaction costs for these acquisitions. The results of operations for these acquisitions are included in the consolidated financial statements since the respective effective dates. MediPlan Corporation, with Medicaid membership in Ohio, is included in the Medicaid Managed Care segment. OptiCare Managed Vision, Inc., a managed vision provider, Cardium Health Services Corporation, a chronic disease management provider, and Health Dimensions of Florida, Inc., a provider of after hours nurse triage services, are included in the Specialty Services segment. For these acquisitions, goodwill of $7,150 and $17,929 was allocated to the Medicaid Managed Care segment and Specialty Services segment, respectively. Pro forma disclosures related to these acquisitions have been excluded as immaterial. Acquired goodwill, totaling $6,714, is deductible for income tax purposes.

6. Impairment Loss

In August 2006, FirstGuard Health Plan Kansas, Inc. (FirstGuard Kansas), a wholly owned subsidiary, received notification from the Kansas Health Policy Authority that its Medicaid contract scheduled to terminate December 31, 2006 will not be renewed. The Company appealed this decision and the administrative appeal was denied. The Company is currently reviewing all available remedies and will continue to pursue its active pending petition in Kansas state court. As a result of these events, the Company concluded it was necessary to conduct an impairment analysis of the identifiable intangible assets and goodwill of the FirstGuard reporting unit, which encompasses both the Kansas and Missouri FirstGuard health plans.

The fair value of the FirstGuard reporting unit was determined using discounted expected cash flows and estimated market value. The impairment analysis resulted in an impairment of $87,091 recorded as impairment loss in the consolidated statement of earnings. The impaired identifiable intangible assets of $5,993 and goodwill of $81,098 were reported under the Medicaid Managed Care segment. The goodwill portion of the impairment loss is not deductible for tax purposes.

Goodwill balances and the changes therein are as follows:

	Medicaid Managed Care	Specialty Services	Total
Balance as of December 31, 2005	$ 123,890	$ 33,388	$ 157,278
Acquisitions	7,150	54,829	61,979
Impairment loss	(81,098)	—	(81,098)
Other adjustments	(263)	(1,377)	(1,640)
Balance as of September 30, 2006	$ 49,679	$ 86,840	$ 136,519

7. Debt

At September 30, 2006, total debt outstanding was $169,461, including current maturities of $1,032. The total debt outstanding consisted of $142,500 under the Company's $300,000 five-year Revolving Credit Agreement discussed below, $12,609 of mortgage notes payable, $8,359 under the three-year Revolving Loan Agreement discussed below and $5,993 of capital leases and other debt.

In May 2006, the Company executed a three-year $25,000 Revolving Loan Agreement. Borrowings under the agreement bear interest based upon LIBOR rates plus 1.5%. Subject to the terms and conditions of the agreement, the proceeds of the Revolving Loan may only be used for the acquisition of certain properties contiguous to the Company's corporate headquarters. The outstanding borrowings at September 30, 2006 bore interest at 6.8%.

In September 2006, the Company executed an amendment to the five-year Revolving Credit Agreement dated September 14, 2004 with various financial institutions, for which LaSalle Bank National Association serves as administrative agent and co-lead arranger. The amendment increases the total amount available under the credit agreement to $300,000 from $200,000, including a sub-facility for letters of credit in an aggregate amount up to $75,000. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. There is a commitment fee on the unused portion of the agreement that ranges from 0.15% to 0.275% depending on the total debt-to-EBITDA ratio. The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. The agreement will expire in September 2011. The outstanding borrowings at September 30, 2006 bore interest at LIBOR plus 1.25%, or 6.6%.

8. 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,	
	2006	2005	2006	2005
Net earnings (loss)	$ (71,193)	$ 12,106	$ (57,462)	$ 41,766
Shares used in computing per share amounts:				
Weighted average number of common shares outstanding	43,219,053	42,582,129	43,126,062	42,120,149
Common stock equivalents (as determined by applying the treasury stock method)	—	2,696,199	—	2,958,703
Weighted average number of common shares and potential dilutive common shares outstanding	43,219,053	45,278,328	43,126,062	45,078,852
Basic earnings (loss) per common share	$ (1.65)	$ 0.28	$ (1.33)	$ 0.99
Diluted earnings (loss) per common share	$ (1.65)	$ 0.27	$ (1.33)	$ 0.93

The calculation of diluted earnings per common share for the three months and nine months ended September 30, 2005 excludes the impact of 197,500 and 265,155, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

9. Stockholders' Equity

In November 2005, the Company's board of directors adopted a stock repurchase program authorizing the Company to repurchase up to 4,000,000 shares of common stock from time to time on the open market or through privately negotiated transactions. The repurchase program extends through October 31, 2007, but the Company reserves the right to suspend or discontinue the program at any time. During the nine months ended September 30, 2006, the Company repurchased 367,900 shares at an average price of $19.61 and an aggregate cost of $7,214.

10. Contingencies

Two class action lawsuits were filed against the Company and certain of its officers and directors in the United States District Court for the Eastern District of Missouri, one in July, or the July Class Action Lawsuit, and one in August, or the August Class Action Lawsuit and collectively, the Class Action Lawsuits, on behalf of purchases of the Company's common stock from June 21, 2006 through July 17, 2006. The Class Action Lawsuits allege that the Company and certain of its officers and directors violated federal securities laws by issuing a series of materially false statements prior to the announcement of its fiscal 2006 second quarter results. According to the Class Action Lawsuits, these allegedly materially false statements had the effect of artificially inflating the price of the Company's common stock, which subsequently dropped after the issuance of a press release announcing the Company's preliminary fiscal 2006 second quarter earnings and revised guidance. All parties have sought consolidation of the Class Action Lawsuits. In addition, the Company routinely is subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters is uncertain, the Company does not expect the results of these matters to have a material effect on its financial position or results of operations.

11. Segment Information

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, disease management, managed vision, nurse triage, pharmacy benefits management and treatment compliance functions.

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

Segment information for the three months ended September 30, 2006, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 581,371	$ 49,878	$ —	$ 631,249
Revenue from internal customers	24,511	73,620	(98,131)	—
Total revenue	$ 605,882	$ 123,498	$ (98,131)	$ 631,249
Earnings (loss) from operations	$ (69,008)	$ 2,452	$ —	$ (66,556)

Segment information for the three months ended September 30, 2005, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 373,589	$ 27,053	$ —	$ 400,642
Revenue from internal customers	18,488	9,475	(27,963)	—
Total revenue	$ 392,077	$ 36,528	$ (27,963)	$ 400,642
Earnings (loss) from operations	$ 15,542	$ (402)	$ —	$ 15,140

Segment information for the nine months ended September 30, 2006, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 1,444,413	$ 137,207	$ —	$ 1,581,620
Revenue from internal customers	67,513	140,100	(207,613)	—
Total revenue	$ 1,511,926	$ 277,307	$ (207,613)	$ 1,581,620
Earnings (loss) from operations	$ (52,339)	$ 4,685	$ —	$ (47,654)

Segment information for the nine months ended September 30, 2005, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 1,052,102	$ 30,544	$ —	$ 1,082,646
Revenue from internal customers	53,306	26,108	(79,414)	—
Total revenue	$ 1,105,408	$ 56,652	$ (79,414)	$ 1,082,646
Earnings (loss) from operations	$ 60,194	$ (1,416)	$ —	$ 58,778

At September 30, 2006, the Medicaid Managed Care and Specialty Services segment had total assets of $756,108 and $57,733, respectively.

In 2006, the Company reassessed the calculations used to determine the appropriate proportion of certain costs allocated to each of our two segments. This assessment included an evaluation of whether the costs should be allocated based on revenue, number of claims, or headcount measures and altered the proportion of certain general and administrative expenses. For the three months and nine months ended September 30, 2006, the altered percentages resulted in the allocation of an additional $3,510 and $9,679, respectively, to the Medicaid Managed Care segment than would have been allocated under the previous formulas.

12. Comprehensive Earnings

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2006	2005	2006	2005
Net earnings (loss)	$ (71,193)	$ 12,106	$ (57,462)	$ 41,766
Reclassification adjustment, net of tax	8	25	71	92
Change in unrealized gain (loss) on investments, net of tax	912	(738)	327	(1,207)
Total comprehensive earnings (loss)	$ (70,273)	$ 11,393	$ (57,064)	$ 40,651

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, 2005. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth below under Item 1A. "Risk Factors."

OVERVIEW

We are a multi-line healthcare enterprise operating primarily in two segments. Our government services Medicaid Managed Care segment provides Medicaid and Medicaid-related programs to organizations and individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program (SCHIP) and Supplemental Security Income (SSI). Our Specialty Services segment provides specialty services, including behavioral health plans, disease management, managed vision, nurse triage, pharmacy benefits management and treatment compliance to our own subsidiaries at market-based rates, state programs, commercial organizations and other healthcare organizations. We also serve individuals, through long-term care programs, who are dually eligible under Medicaid and Medicare.

Our 2006 third quarter performance is summarized as follows:

- Quarter-end Medicaid Managed Care membership of 1,169,700.
- Revenues of $631.2 million, an increase of 57.6%.
- Medicaid and SCHIP health benefits ratio (HBR) of 82.0%, SSI HBR of 84.1% and Specialty Services HBR of 82.9%.
- Medicaid Managed Care general and administrative (G&A) expense ratio of 12.1% and Specialty Services G&A ratio of 17.0%.
- Operating loss of $66.6 million, including a pre-tax, non-cash intangible asset impairment charge of $87.1 million recognized as a result of the contract non-renewal notification from the state of Kansas.
- Diluted net loss per share of $1.65 (including a $1.96 after-tax non-cash impairment charge as described above).
- Operating cash flows of $110.1 million for the three months ended September 30, 2006.

Over the last year we have experienced membership and revenue growth in our Medicaid Managed Care segment including membership growth of 38.0% since September 30, 2005. Our membership growth would have been 24.7% if we exclude our membership in Kansas from the total membership as of September 30, 2006. Driving our growth are the following new contracts and acquisitions:

- Effective September 1, 2006, we began operating under a new contract and expanded operations in Texas to include 11,500 Medicaid and SCHIP members in the Corpus Christi, Austin and Lubbock markets.
- In Georgia, we began managing care for Medicaid and SCHIP members in the Atlanta and Central regions effective June 1, 2006 and Southwest region effective September 1, 2006. At September 30, 2006, our membership in Georgia was 252,600.
- Beginning July 1, 2006, we began operating under new contracts with the State of Ohio to manage care for 15,800 Medicaid members by entering seven new counties in the East Central market. This expansion is part of the State of Ohio's efforts to regionalize its Medicaid program.
- Effective June 1, 2006, we acquired MediPlan Corporation (MediPlan) and began managing care for an additional 13,600 members in Ohio. The results of operations of this entity are included in our consolidated financial statements beginning June 1, 2006.
- We increased our membership by 12.4% in Indiana.
- We increased our membership by 16.1% in New Jersey.

During the third quarter of 2006, we were notified by the Kansas Health Policy Authority that our Medicaid contract in Kansas will not be renewed beyond December 31, 2006. This development is discussed below under the caption "Impairment Loss." As of September 30, 2006, our membership in Kansas was 112,400.

We have the following new contracts or preliminary contract awards to expand our operations in Ohio and Texas:

- During 2006, we were awarded a contract in Ohio to provide managed care for Medicaid members in the Northwest market. Transition of these members to our health plan commenced in October 2006. This expansion is part of the State of Ohio's efforts to regionalize its Medicaid program.

- During the second quarter of 2006, we were awarded a contract in Texas to provide managed care for SSI recipients in the San Antonio and Corpus Christi markets. Membership operations are scheduled to commence in January 2007.
- During 2006, we received preliminary notification of an award in Ohio to provide managed care for Medicaid Aged, Blind and Disabled (ABD) members in four regions. If the award receives regulatory approval, implementation is expected to take place on a region-by-region basis commencing in 2007.

Our Specialty Services segment has experienced significant year over year growth largely because of the following acquisitions and contract awards:

- Effective October 1, 2006, we began performing under our contract with the Arizona Health Care Cost Containment System to provide long term care services in the Maricopa, Yuma and LaPaz counties in Arizona.
- Effective July 1, 2006, we acquired the managed vision business of OptiCare Managed Vision, Inc. (OptiCare). The results of operations of this entity are included in our consolidated financial statements beginning July 1, 2006.
- Effective May 9, 2006, we acquired Cardium Health Services Corporation (Cardium), a disease management company. The results of operations of this entity are included in our consolidated financial statements beginning May 9, 2006.
- Effective January 1, 2006, we acquired US Script, Inc. (US Script), a pharmacy benefits manager (PBM). The results of operations of this entity are included in our consolidated financial statements beginning January 1, 2006.
- Effective July 22, 2005, we acquired AirLogix, Inc. (AirLogix), a disease management provider. The results of operations of this entity are included in our consolidated financial statements since July 22, 2005.
- Effective July 1, 2005, we began performing under our contract with the State of Arizona to facilitate the delivery of mental health and substance abuse services to behavioral health recipients in Arizona.

RESULTS OF OPERATIONS AND KEY METRICS

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

	Three Months Ended September 30,			Nine Months Ended September 30,		
	2006	2005	% Change 2005-2006	2006	2005	% Change 2005-2006
Premium	$ 610.6	$ 395.6	54.3%	$ 1,522.3	$ 1,075.0	41.6%
Service	20.6	5.0	—	59.3	7.6	—
Total revenues	631.2	400.6	57.6%	1,581.6	1,082.6	46.1%
Medical costs	501.3	331.1	51.4%	1,263.3	881.0	43.4%
Cost of services	15.4	2.0	—	45.3	3.6	—
General and administrative expenses	94.0	52.4	79.2%	233.7	139.2	67.8%
Impairment loss	87.1	—	—	87.1	—	—
Earnings (loss) from operations	(66.6)	15.1	—	(47.8)	58.8	—
Investment and other income, net	1.5	1.6	(5.2)%	4.6	5.1	(10.9)%
Earnings (loss) before income taxes	(65.1)	16.7	—	(43.2)	63.9	—
Income tax expense	6.1	4.6	32.6%	14.3	22.1	(35.1)%
Net earnings (loss)	$ (71.2)	$ 12.1	—	$ (57.5)	$ 41.8	—
Diluted earnings (loss) per common share	$ (1.65)	$ 0.27	—	$ (1.33)	$ 0.93	—

Revenues and Revenue Recognition

Our Medicaid Managed Care segment generates revenues primarily from premiums we receive from the states in which we operate health plans. We receive a fixed premium per member per month pursuant to our state contracts. We generally receive premium payments during the month we provide services and recognize premium revenue during the period in which we are obligated to provide services to our members. Some contracts allow for additional premium related to certain supplemental services provided such as maternity deliveries. Revenues are recorded based on membership and eligibility data provided by the states, which may be adjusted by the states for updates to this data. These adjustments have been immaterial in relation to total revenue recorded and are reflected in the period known.

Our Specialty Services segment generates revenues under contracts with our own subsidiaries at market-based terms, as well as to state programs, commercial organizations, and other healthcare organizations. Revenues are recognized when the related services are provided or as ratably earned over the covered period of service. For performance-based contracts, we do not recognize revenue subject to refund until data is sufficient to measure performance.

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

Our total revenue increased year over year primarily because of 1) membership growth in the Medicaid Managed Care segment, 2) premium rate increases, and 3) growth in our Specialty Services segment.

1. Membership growth

From September 30, 2005 to September 30, 2006, we increased our membership by 38.0%. The following table sets forth our membership by state in our Medicaid Managed Care segment:

	September 30,	
	2006	2005
Georgia	252,600	—
Indiana	198,100	176,300
Kansas	112,400	107,600
Missouri	32,200	37,300
New Jersey	59,100	50,900
Ohio	88,300	58,100
Texas	259,900	243,600
Wisconsin	167,100	173,900
Total	1,169,700	847,700

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

	September 30,	
	2006	2005
Medicaid	922,300	657,500
SCHIP	229,400	176,900
SSI	18,000	13,300
Total	1,169,700	847,700

Our operations commenced in the Atlanta and Central regions of Georgia on June 1, 2006 and the Southwest region on September 1, 2006. We expect our total membership in Georgia to increase in the fourth quarter of 2006 as the State continues to assign members to health plans in the Southwest region. From September 30, 2005 to September 30, 2006, we increased our membership in Ohio through the MediPlan acquisition while also adding members under our new contract in the East Central market. Our membership increased in Indiana and New Jersey from additions to our provider networks, service of additional counties and growth in the overall number of Medicaid beneficiaries. In Texas, we increased our membership through new contracts in the Corpus Christi, Austin, and Lubbock markets. In Kansas, we increased our membership by eliminating a ceiling on our total membership with the State. Our membership decreased in Wisconsin and Missouri because of more stringent state eligibility requirements for the Medicaid and SCHIP programs and eligibility administration issues in Wisconsin.

2. Premium rate increases

During the nine months ended September 30, 2006, we received premium rate increases, net of increases related to premium tax enactments, ranging from 1.8% to 9.5%, or 5.5% on a composite basis across our markets.

3. Specialty Services segment growth

In 2005, we began performing under our behavioral health contracts with the states of Arizona and Kansas. At September 30, 2006, our behavioral health company, Cenpatico, provided behavioral health services to 94,500 members in Arizona, 37,500 members in Kansas and 998,200 members through contracts with our health plans compared to 94,300 members in Arizona, 37,500 members in Kansas and 652,000 members through contracts with our health plans at September 30, 2005. In July 2005, we began offering disease management services through our acquisition of AirLogix. In January 2006, we began offering pharmacy benefits management services through our acquisition of US Script. Additionally, in May 2006, we expanded our disease management services through our acquisition of Cardium. In July 2006, we began offering managed vision care through our acquisition of OptiCare. The increase in service revenue reflects the acquisitions of AirLogix, US Script, and Cardium. For the three months ended September 30, 2006, total Specialty Services revenue (before inter-company eliminations) was $123.5 million compared to $36.5 million for the comparable period in 2005. Approximately 40% of this 2006 revenue was to external customers as compared to 74% in the third quarter of 2005.

Operating Expenses

Medical Costs

Our medical costs include payments to physicians, hospitals, and other providers for healthcare and specialty services claims. Medical costs also include estimates of medical expenses incurred but not yet reported, or IBNR, and estimates of the cost to process unpaid claims. Each month we estimate our IBNR based on a number of factors, including inpatient hospital utilization data and prior claims experience. When we commence operations in a new state or region, we estimate our medical claims liabilities on state provided historical actuarial data and limited actual claims data. As part of our 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 employ actuarial professionals and use the services of independent actuaries who are contracted to review our estimates quarterly. While we believe that our process for estimating IBNR is actuarially sound, we cannot assure you that healthcare claim costs will not materially differ from our estimates.

Our results of operations depend on our ability to manage expenses related to health benefits and to accurately predict costs incurred. Our HBR 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 HBR for our external membership by member category:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2006	2005	2006	2005
Medicaid and SCHIP	82.0%	83.1%	82.8%	81.6%
SSI	84.1	96.2	86.2	92.6
Specialty Services	82.9	87.2	83.5	88.7

Our Medicaid and SCHIP HBR for the three and nine months ended September 30, 2006 were 82.0% and 82.8%, respectively, a decrease of 1.1% and increase of 1.2% over the comparable 2005 periods. The HBR for the three and nine months ended September 30, 2005 included $4.5 million for settlement of a lawsuit with Aurora Health Care, Inc. (Aurora), a provider of medical professional services to our Wisconsin health plan. This settlement increased the HBR by 1.2% and 0.5% for the three and nine months ended September 30, 2005, respectively. The decrease for the three months ended September 30, 2006 was caused by premium rate increases in certain markets, an increase in maternal delivery revenue, and the effect of the Aurora settlement offset by a 8.9% increase in average in-patient days and higher physician costs. The HBR for the three months ended September 30, 2006 did not include any significant adverse medical cost development. The increase in HBR for the nine months ended September 30, 2006 is caused primarily by increased cost trends for maternity related costs including neonatal, increased physician costs, and increased costs associated with injectibles such as Synagis and Somatropin.

Our Specialty Services HBR for 2006 includes nine months of the behavioral health contracts in Arizona and Kansas and three months of OptiCare. The 2005 results include nine months of our behavioral health contract in Kansas and three months of Arizona results.

Cost of Services

Our cost of services expense includes all direct costs to support the local functions responsible for generation of our service revenues. These expenses consist of the salaries and wages of the professionals and teachers who provide the services and expenses related to facilities and equipment used to provide services. Cost of services also includes the pharmacy costs incurred by our PBM related to its external business. Cost of services rose $13.4 and $41.7 million for the three and nine months ended September 30, 2006, respectively, over the comparable periods in 2005. The increase in cost of services reflects the acquisitions of AirLogix, US Script and Cardium.

General and Administrative Expenses

Our G&A expenses primarily reflect wages and benefits, including stock compensation expense, and other administrative costs related to health plans, specialty companies and our centralized functions that support all of our business units. Our major centralized functions are finance, information systems and claims processing. Premium tax or similar assessments (collectively, premium taxes) are also classified as G&A expenses. G&A expenses increased for the three and nine months ended September 30, 2006 over the comparable periods in 2005 primarily due to expenses for additional facilities and staff to support our growth, especially in Arizona and Georgia, an increase in premium taxes, and the adoption of SFAS 123R on January 1, 2006. Premium taxes totaled $13.8 million and $25.0 million in the three and nine months ended September 30, 2006, respectively, compared to $1.8 million and $5.3 million, respectively, for the comparable periods in 2005. The results for the three and nine months ended September 30, 2006 include $0.8 million and $10.2 million, respectively, of implementation

expenses in Georgia. The results for the three and nine months ended September 30, 2006 include $2.7 million and $7.6 million, respectively, of stock compensation expense as a result of adopting SFAS 123R on January 1, 2006.

Our G&A expense ratio represents G&A expenses as a percentage of total revenues and reflects the relationship between revenues earned and the costs necessary to earn those revenues. The following table sets forth the G&A expense ratios by business segment:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2006	2005	2006	2005
Medicaid Managed Care	12.1%	10.6%	12.1%	10.6%
Specialty Services	17.0	30.2	18.3	38.9

The increase in the Medicaid Managed Care G&A expense ratio in the nine months ended September 30, 2006 reflects the effect of the enactment of new premium taxes. Premium taxes had the effect of increasing the Medicaid Managed Care G&A ratio by 2.1% and 1.5% in the three and nine months ended September 30, 2006, respectively, compared to 0.4% in the three and nine months ended September 30, 2005.

The Specialty Services G&A expense ratio varies depending on the nature of the services provided and will generally be higher than the Medicaid Managed Care G&A expense ratio. The results for the three and nine months ended September 30, 2006 reflect the operations of our behavioral health company in Arizona, the acquisitions of US Script and AirLogix, as well as the acquisition of Cardium effective May 9, 2006, and OptiCare effective July 1, 2006. The results for the nine months ended September 30, 2006 include approximately $0.7 million in start-up costs related to our long-term care contract in Arizona. The results for the nine months ended September 30, 2005 included approximately $1.5 million in start-up costs related to our behavioral health contract in Arizona.

In 2006, we reassessed the calculations used to determine the proportion of certain costs allocated among each of our two segments. This assessment included an evaluation of whether the costs should be allocated based on revenue, number of claims, or headcount measures and altered the proportion of certain G&A costs. The altered percentages resulted in the allocation of an additional $3.5 million and $9.7 million to the Medicaid Managed Care segment in the three and nine months ended September 30, 2006 than would have been allocated under the previous formulas.

Impairment Loss

In August 2006, FirstGuard Health Plan Kansas, Inc. (FirstGuard Kansas), our wholly owned subsidiary, received notification from the Kansas Health Policy Authority that its Medicaid contract scheduled to terminate December 31, 2006 will not be renewed. We appealed this decision and the initial administrative appeal was denied. We are currently reviewing all available remedies and will continue to pursue our active pending petition in Kansas state court. There is a state court hearing scheduled on October 26th to review our request for judicial review and injunctive relief. As a result of these events, we concluded it was necessary to conduct an impairment analysis of the identifiable intangible assets and goodwill of the FirstGuard reporting unit, which encompasses both the Kansas and Missouri FirstGuard health plans as part of our preparation of financial statements for the period ended September 20, 2006.

The fair value of our FirstGuard reporting unit was determined using discounted expected cash flows and estimated market value. The impairment analysis resulted in a pre-tax, non-cash impairment charge of $87.1 million recorded as impairment loss in the consolidated statement of earnings. The impaired identifiable intangible assets of $6.0 million and goodwill of $81.1 million, respectively, were reported under the Medicaid Managed Care segment. We continue to monitor the status of the appeal. Various scenarios could trigger further impairment of goodwill and other assets, or other shutdown costs such as severance. As of September 30, 2006, our FirstGuard reporting unit had goodwill and net intangible assets of $6.8 million. Our Kansas health plan contributed $63.7 million and $174.6 million of revenue for the three and nine months ended September 30, 2006, respectively.

Other Income (Expense)

Other income (expense) consists principally of investment income from our cash and investments and interest expense on our debt. Investment and other income increased $1.8 and $4.6 million for the three and nine months ended September 30, 2006 over the comparable period in 2005 primarily as a result of an increase in market interest rates and larger investment balances. Interest expense increased $1.9 million and $5.2 million for the three and nine months ended September 30, 2006 over the comparable period in 2005 primarily from increased borrowings under our credit facilities.

Income Tax Expense

Our effective tax rate for the nine months ended September 30, 2006 was (33.2)% compared to 34.6% for the corresponding period in 2005. The change was primarily due to the 2006 non-deductible goodwill impairment charge. Excluding the intangible asset impairment, our 2006 estimated effective tax rate is 38%. The 2005 effective tax rate included lower expense resulting from the resolution of state income tax examinations and the recognition of deferred tax benefits related to a change in law. If we are ultimately unsuccessful in our attempts to renew our Kansas Medicaid contract, any potential tax deduction would be based on the stock basis of the applicable subsidiary, not its individual assets. The potential timing of such a deduction can not be determined at this time.

Earnings Per Share and Shares Outstanding

Our earnings per share calculations in 2006 reflect lower diluted weighted average shares outstanding resulting from the exclusion of the effect of outstanding stock awards which would be anti-dilutive to net earnings.

LIQUIDITY AND CAPITAL RESOURCES

We finance our activities primarily through operating cash flows and borrowings under our revolving credit facility. Our operating activities provided cash of $124.6 million in the nine months ended September 30, 2006 compared to $44.9 million in the comparable period in 2005. The increase in cash flow from operations in 2006 reflects an increase in medical claims liabilities primarily from the commencement of our operations in Georgia and an increase in accounts payable and accrued expenses. The increase in premium and related receivables in 2006 reflects an increase in maternal delivery receivables, reimbursements due to us from providers including amounts due under capitated risk-sharing contracts and the acquisition of US Script.

Our investing activities used cash of $141.8 million and $51.8 million in the nine months ended September 30, 2006 and 2005, respectively. During 2006, our investing activities primarily consisted of the acquisitions of US Script, Cardium, MediPlan, and OptiCare. Based on the environment in the state of Missouri, we are evaluating potential strategic alternatives for our health plan in Missouri. Our investing activities in 2006 also included additions to 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, 2006, our investment portfolio consisted primarily of fixed-income securities with an average duration of 1.3 years. Cash is invested in investment vehicles such as asset-backed securities, 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.

We spent $39.5 million and $16.8 million on capital assets in the nine months ended September 30, 2006 and 2005, respectively. The expenditures in 2006 included $21.4 million for computer hardware and software. We anticipate spending an additional $12 million on capital expenditures in 2006 primarily related to information systems.

The expenditures in 2006 also included $9.5 million for several properties contiguous to our corporate headquarters as part of our redevelopment agreement with the City of Clayton, Missouri. We anticipate spending approximately $20 million for additional property in Clayton, Missouri related to this agreement. In the second quarter of 2006, our subsidiary executed a three-year, $25 million revolving credit facility to finance the property already acquired or expected to be acquired under the redevelopment agreement. As of September 30, 2006 we had $8.4 million in borrowings outstanding under this credit facility.

Our financing activities provided cash of $70.3 million in the nine months ended September 30, 2006 compared to $44.2 million in the nine months ended September 30, 2005. During 2006, our financing activities primarily related to proceeds from borrowings under our Revolving Credit Agreement. These borrowings were used primarily for our investing activities in conjunction with the acquisition of US Script, Cardium and MediPlan.

At September 30, 2006, we had working capital, defined as current assets less current liabilities, of $40.5 million as compared to $58.0 million at December 31, 2005. Our investment policies are 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 $267.9 million at September 30, 2006 and $204.1 million at December 31, 2005. Long-term investments were $172.2 million at September 30, 2006 and $146.2 million at December 31, 2005, including restricted deposits of $25.6 million and $22.6 million, respectively. At September 30, 2006, cash and investments held by our unregulated entities totaled $29.0 million while cash and investments held by our regulated entities totaled $411.1 million.

In September 2006, we executed an amendment to our revolving credit agreement. The amendment increases the total amount available under the credit agreement to $300 million from $200 million, including a sub-facility for letters of credit in an aggregate amount up to $75 million. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. There is a commitment fee on the unused portion of the agreement that ranges from 0.15% to 0.275% depending on the total debt to EBITDA ratio. The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt to EBITDA ratios and minimum tangible net worth. The agreement will expire in September 2011. As of September 30, 2006, we had $142.5 million in borrowings outstanding under the agreement and $15.6 million in letters of credit outstanding, leaving an availability of $141.9 million. As of September 30, 2006, we were in compliance with all covenants.

Our board of directors adopted a stock repurchase program authorizing us to repurchase up to 4,000,000 shares of common stock from time to time on the open market or through privately negotiated transactions. The repurchase program extends through October 31, 2007, but we reserve the right to suspend or discontinue the program at any time. During the nine months ended September 30, 2006, we repurchased 367,900 shares at an average price of $19.61. We have established a trading plan with a registered broker to repurchase shares under certain market conditions.

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

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, 2006. Based on our operating plan, we expect that our available funding will be sufficient to finance our operations 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, 2006, our subsidiaries had aggregate statutory capital and surplus of $214.3 million, compared with the required minimum aggregate statutory capital and surplus requirements of $133.4 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, 2006, our Georgia, Indiana, New Jersey, Ohio, Texas and Wisconsin health plans were in compliance with the risk-based capital requirements enacted in those states. If adopted by Kansas or Missouri, we believe we would be in compliance with the risk-based capital requirements for these subsidiaries. We continue to monitor the requirements in Kansas and Missouri 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 July 2006, the FASB issued Interpretation 48 (FIN 48), "Accounting for Uncertainty in Income Taxes," an interpretation of FASB Statement No. 109, "Accounting for Income Taxes." FIN 48 clarifies the accounting for uncertainty in income taxes recognized in an enterprise's financial statements in accordance with FASB Statement No. 109. FIN 48 describes a recognition threshold and measurement attribute for financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return and also provides guidance on derecognition, classification, interest and penalties, accounting in interim periods, disclosure and transition. The Interpretation is effective for fiscal years beginning after December 15, 2006. We are currently assessing the estimated effect of FIN 48 on the financial condition and results of operations upon adoption on January 1, 2007.

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," "can," "continue" or the 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" and Item 1A. "Risk Factors." 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 healthcare 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 affect 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.

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

INVESTMENTS

As of September 30, 2006, we had short-term investments of $67.4 million and long-term investments of $172.2 million, including restricted deposits of $25.6 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, asset-backed securities, 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. Our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at September 30, 2006, the fair value of our fixed income investments would decrease by approximately $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 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 in recent years. 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 may be required. 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 — Our management, with the participation of our chief executive officer and chief financial officer, evaluated the effectiveness of our disclosure controls and procedures as of September 30, 2006. The term "disclosure controls and procedures," as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act, means controls and other procedures of a company that are designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the company's management, including its principal executive and principal financial officers, as appropriate to allow timely decisions regarding required disclosure. Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving their objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Based on the evaluation of our disclosure controls and procedures as of September 30, 2006, our chief executive officer and chief financial officer concluded that, as of such date, our disclosure controls and procedures were effective at the reasonable assurance level.

Changes in Internal Control Over Financial Reporting— No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the quarter ended September 30, 2006 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

PART II

OTHER INFORMATION

ITEM 1. ***Legal Proceedings.***

Two class action lawsuits were filed against us and certain of our officers and directors in the United States District Court for the Eastern District of Missouri, one in July, or the July Class Action Lawsuit, and one in August, or the August Class Action Lawsuit and collectively, the Class Action Lawsuits, on behalf of purchases of our common stock from June 21, 2006 through July 17, 2006. The Class Action Lawsuits allege that we and certain of our officers and directors violated federal securities laws by issuing a series of materially false statements prior to the announcement of our fiscal 2006 second quarter results. According to the Class Action Lawsuits, these allegedly materially false statements had the effect of artificially inflating the price of our common stock, which subsequently dropped after the issuance of a press release announcing our preliminary fiscal 2006 second quarter earnings and revised guidance. All parties have sought consolidation of the Class Action Lawsuits. In addition, we routinely are subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters is uncertain, we do not expect the results of these matters to have a material effect on our financial position or results of operations.

ITEM 1A. ***Risk Factors.***

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

You should carefully consider the risks described below before making an investment decision. The trading price of our common stock could decline due to any of these risks, in which case you could lose all or part of your investment. You should also refer to the other information in this filing, including our consolidated financial statements and related notes. The risks and uncertainties described below are those that we currently believe may materially affect our Company. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial also may become important factors that affect our Company.

Risks Related to Being a Regulated Entity

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

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

For example, in October 2005, the Centers for Medicare & Medicaid Services, or CMS, published an interim final rule regarding the estimation and recovery of improper payments made under Medicaid and SCHIP. This rule requires a CMS contractor to sample selected states each year to estimate improper payments in Medicaid and SCHIP and create national and state specific error rates. Each state will be selected for review once every three years for each program. States are required to repay to CMS the federal share of any overpayments identified.

On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 to reduce the size of the federal deficit. The Act reduces federal spending by nearly $40 billion over the next 5 years, including a $5 billion reduction in Medicaid. The Act reduces spending by cutting Medicaid payments for prescription drugs and gives states new power to reduce or reconfigure benefits. This law may also lead to lower Medicaid reimbursements in some states. The Bush administration's budget proposal also seeks to further reduce total federal funding for the Medicaid program by $14 billion over the next five years. In addition, the Bush administration has proposed freezing federal spending for SCHIP at the levels set in 2007 for ten years. States also periodically consider reducing or reallocating the amount of money they spend for Medicaid, SCHIP and SSI. In recent years, the majority of states have implemented measures to restrict Medicaid, SCHIP and SSI costs and eligibility.

Changes to Medicaid, SCHIP and SSI programs could reduce the number of persons enrolled in or eligible for these programs, reduce the amount of reimbursement or payment levels, or increase our administrative or healthcare costs under those programs. 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, SCHIP and SSI. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. Our contracts with various states are generally intended to run for one or two years and may be extended for one or two additional years if the state or its agent elects to do so. Our current contracts are set to expire between December 31, 2006 and September 30, 2009. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. For example, on August 25, 2006, we received notification from the Kansas Health Policy Authority that FirstGuard Health Plan Kansas, Inc.'s contract with the state ending on December 31, 2006 will not be renewed or extended. 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. Our contracts could also be terminated if we fail to perform in accordance with the standards set by state regulatory agencies. For example, the Indiana contract under which we operate can

be terminated by the state without cause. 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 the financial interests of providers and members rather than our investors could force us to change how we operate and could harm our business.

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

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

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

Regulations may decrease the profitability of our health plans.

Our Texas plan is required to pay a rebate to the State of Texas in the event profits exceed established levels. Similarly, our New Jersey plan is required to pay a rebate to the State of New Jersey 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. Certain states, including but not limited to 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.

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

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

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

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

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

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

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

Many aspects of our business are affected by government laws and regulation. The issuance of new regulations, or judicial or regulatory guidance regarding existing regulations, could require changes to many of the procedures we currently use to conduct our business, which may lead to additional costs that we have not yet identified. We do not know whether, or the extent to which, we will be able to recover from the states our costs of complying with these new regulations. The costs of any such future compliance efforts could have a material adverse effect on our business.

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

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

Changes in healthcare law and benefits may reduce our profitability.

Numerous proposals relating to changes in healthcare law have been introduced, some of which have been passed by Congress and the states in which we operate or may operate in the future. Changes in applicable laws and regulations are continually being considered, and interpretations of existing laws and rules may also change from time to time. We are unable to predict what regulatory changes may occur or what effect any particular change may have on our business. For example, these changes could reduce the number

of persons enrolled or eligible to enroll in Medicaid, reduce the reimbursement or payment levels for medical services or reduce benefits included in Medicaid coverage. We are also unable to predict whether new laws or proposals will favor or hinder the growth of managed healthcare in general. Legislation or regulations that require us to change our current manner of operation, benefits provided or our contract arrangements may seriously harm our operations and financial results.

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

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

Changes in federal funding mechanisms may reduce our profitability.

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

In April 2004, the Bush administration adopted a policy that seeks to reduce states' use of intergovernmental transfers for the states' share of Medicaid program funding. By restricting the use of intergovernmental transfers, 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 revised cost-sharing requirements for some beneficiaries and requires states to reimburse the federal Medicare program for costs of prescription drug coverage provided to beneficiaries who are enrolled simultaneously in both the Medicaid and Medicare programs. The Bush administration has also proposed to further reduce total federal funding for the Medicaid program by $14 billion over the next five years. These changes may reduce the availability of funding for some states' Medicaid programs, which could adversely affect our growth, operations and financial performance. In addition, the new Medicare prescription drug benefit is interrupting the distribution of prescription drugs to many beneficiaries simultaneously enrolled in both Medicaid and Medicare, prompting several states to pay for prescription drugs on an unbudgeted, emergency basis without any assurance of receiving reimbursement from the federal Medicaid program. These expenses may cause some states to divert funds originally intended for other Medicaid services which could adversely affect our growth, operations and financial performance.

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

Our operations are conducted through our wholly owned subsidiaries, which include health maintenance organizations, or HMOs, and managed care organizations, or MCOs. HMOs and MCOs are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Additionally, state regulatory agencies may require, at their discretion, individual HMOs

to maintain statutory capital levels higher than the state regulations. If this were to occur to one of our subsidiaries, we may be required to make additional capital contributions to the affected subsidiary. Any additional capital contribution made to one of the affected subsidiaries could have a material adverse effect on our liquidity and our ability to grow.

If 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 us would be limited, which could harm our ability to implement our business strategy.

Risks Related to Our Business

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

Our health plans rely on other state-operated systems or sub-contractors to qualify, solicit, educate and assign eligible clients into the health plans. The effectiveness of these state operations and sub-contractors can have a material effect on a health plan's enrollment in a particular month or over an extended period. When a state implements new programs to determine eligibility, new processes to assign or enroll eligible clients into health plans, or chooses new contractors, there is an increased potential for an unanticipated impact on the overall number of members assigned into the health plans.

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

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

Receipt of inadequate or significantly delayed 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 revenue, to increase and our profits to decline. In addition, it is possible for a state to increase the rates payable to the hospitals without granting a corresponding increase in premiums to us. If this were to occur in one or more of the states in which we operate, our profitability would be harmed. In addition, if there is a significant delay in our receipt of premiums to offset previously incurred health benefits costs, our earnings could be negatively impacted.

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

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

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

Historically, the acquisition of Medicaid 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.

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.

Our acquisitions may increase costs, liabilities, or create disruptions in our business.

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

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

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

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

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

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

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

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

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

Operations in Georgia, Indiana, Kansas, Texas and Wisconsin historically 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 or other governmental or regulatory actions and decisions, economic conditions and similar factors in those states. For example, in 2006, we were notified by the Kansas Health Policy Authority that our Medicaid contract scheduled to terminate December 31, 2006 will not be renewed. Our inability to continue to operate in any of the states in which we operate would harm our business.

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

We compete for members principally on the basis of size and quality of provider network, benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state Medicaid programs that reimburse providers as care is provided. Subject to limited exceptions by federally approved state applications, the federal government requires that there be choices for Medicaid recipients among managed care programs. Voluntary programs and mandated competition may limit our ability to increase our market share.

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

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

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

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

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

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

We may be unable to attract and retain key personnel.

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

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

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

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

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

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

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

Growth in the number of Medicaid-eligible persons during economic downturns could cause our operating results 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.

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

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

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

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

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

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

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

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

We are a defendant from time to time in lawsuits and regulatory actions relating to our business. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate

outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and operating results. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and may require significant attention from our management. For example, we have been named in a number of recently-filed securities class action lawsuits. In addition, we may in the future be the target of similar litigation. As with other litigation, securities litigation could be costly and time consuming, require significant attention from our management and could harm our business and operating results.

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

Issuer Purchases of Equity Securities (1)
Third Quarter 2006

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs
July 1 — July 31, 2006	10,000	$ 15.59	10,000	3,810,300
August 1 — August 31, 2006	138,200	15.85	138,200	3,672,100
September 1 — September 30, 2006	40,000	15.56	40,000	3,632,100
TOTAL	188,200	$ 15.78	188,200	3,632,100

(1) On November 7, 2005 our Board of Directors adopted a stock repurchase program of up to 4,000,000 shares, which extends through October 31, 2007. During the three months ended September 30, 2006, we did not repurchase any shares other than through this publicly announced program.

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.***

Exhibits.

EXHIBIT NUMBER	DESCRIPTION
10.1	Amendment No. 5 to Credit Agreement dated as of September 14, 2004 among Centene Corporation, the various financial institutions party hereto and LaSalle Bank National Association.
10.2	First Amendment to the contract for Medicaid/Badger Care HMO Services between Managed Health Services Insurance Corp. and Wisconsin Department of Health and Family Services.
10.3	Notice of Renewal for fiscal year 2007 between Peach State Health Plan, Inc. and Georgia Department of Community Health.
12.1	Computation of ratio of earnings to fixed charges.
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.

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 October 24, 2006.

CENTENE CORPORATION

By: /s/ Michael F. Neidorff
Michael F. Neidorff
Chairman and Chief Executive Officer
(principal executive officer)

By: /s/ J. Per Brodin
J. Per Brodin
Senior Vice President, Chief Financial Officer,
Secretary and Treasurer
(principal financial and accounting officer)

Exhibit 10.1

AMENDMENT NO. 5
(dated and effective September 22, 2006)
to
CREDIT AGREEMENT
(that was dated as of September 14, 2004)
by and among
LASALLE BANK NATIONAL ASSOCIATION,
as Administrative Agent and Co-Lead Arranger,
WACHOVIA CAPITAL MARKETS, LLC, as Co-Lead Arranger,
WACHOVIA BANK, NATIONAL ASSOCIATION, as Syndication Agent,
the LENDERS,
and CENTENE CORPORATION,
as Company

In consideration of their mutual agreements herein and for other sufficient consideration, the receipt of which is hereby acknowledged, CENTENE CORPORATION, a Delaware corporation (*Company*), LASALLE BANK NATIONAL ASSOCIATION (*Administrative Agent*), and the Lenders agree as follows:

1. Definitions; Section References. The term *Original Loan Agreement* means the Credit Agreement dated as of September 14, 2004 among Company, Administrative Agent, and the Lenders party thereto, as amended by that certain Amendment No. 1 thereto dated as of July 18, 2005, as further amended by that certain Amendment No. 2 thereto dated as of September 9, 2005, as further amended by that certain Amendment No. 3 thereto dated as of November 7, 2005, as further amended by that certain Amendment No. 4 thereto dated as of April 7, 2006. The term *this Amendment* means this Amendment No. 5. The term *Loan Agreement* means the Original Loan Agreement as amended by this Amendment. Capitalized terms used and not otherwise defined herein have the meanings defined in the Loan Agreement. Section and Exhibit references are to sections of, and exhibits to, respectively, the Original Loan Agreement unless otherwise specified.

2. Conditions to Effectiveness of this Amendment. This Amendment is effective as of September 22, 2006, but only if (i) this Amendment has been duly executed by Company, Administrative Agent, and each Lender, and (ii) all of the documents listed on Exhibit A to this Amendment have been delivered and, as applicable, executed, sealed, attested, acknowledged, certified, or authenticated, each in form and substance satisfactory to Administrative Agent, and all of the requirements described in Exhibit A to this Amendment have been satisfied.

3. Amendments to Original Loan Agreement. The Original Loan Agreement is hereby amended as follows:

3.1. Agent Fee Letter. The definition of “Agent Fee Letter” in Section 1 is deleted in its entirety and replaced with the following:

Agent Fee Letter means the fee letter dated as of August 8, 2006 between the Company and Administrative Agent.

3.2. Applicable Margin. The definition of “Applicable Margin” in Section 1 is amended by deleting the table therein in its entirety and replacing it with the following:

Level	Total Debt to EBITDA Ratio	LIBOR Margin	Base Rate Margin	Non-Use Fee Rate	L/C Fee Rate
I	Greater than or equal to 2.5:1	1.75%	0.25%	0.275%	1.75%
II	Greater than or equal to 2.0:1 but less than 2.5:1	1.50%	0.00%	0.25%	1.50%
III	Greater than or equal to 1.5:1 but less than 2.0:1	1.25%	0.00%	0.225%	1.25%
IV	Greater than or equal to 1.0:1 but less than 1.5:1	1.00%	0.00%	0.175%	1.00%
V	Less than 1.0:1	0.75%	0.00%	0.15%	0.75%

3.3. Centene Plaza Divestiture. The following definition is inserted in Section 1:

Centene Plaza Divestiture means the sale, transfer, or contribution by the applicable Loan Party of its right, title, and interest in and to the real property and improvements known as Centene Plaza on fair and reasonable terms and on an arm's length basis to another Loan Party (of which at least 50% of the Capital Securities are owned directly or indirectly by Company and the remaining Capital Securities are owned directly or indirectly by Company's development partners with respect to the Centene Plaza Project).

3.4. Centene Plaza Documents. The following definition is inserted in Section 1:

Centene Plaza Documents means those loan documents entered into between any applicable Loan Party and the lenders thereunder related to the financing of the Centene Plaza Project, and all notes, instruments, documents, and agreements executed or delivered from time to time in connection therewith, in each case as amended, restated, supplemented or otherwise modified from time to time.

3.5. Centene Plaza Project. The following definition is inserted in Section 1:

Centene Plaza Project means the development and construction of the office building complex project in Clayton, Missouri known as Centene Plaza.

3.6. EBITDA. The definition of "EBITDA" in Section 1 is deleted in its entirety and replaced with the following:

EBITDA means, for any period, Consolidated Net Income for such periodplus, to the extent deducted in determining such Consolidated Net Income, Interest Expense, income tax expense, depreciation and

amortization for such period, non-cash charges associated with stock-based compensation expenses pursuant to the financial reporting guidance of the Financial Accounting Standards Board concerning stock-based compensation as in effect from time to time, and other extraordinary or non-recurring non-cash expenses, minus, to the extent added in determining such Consolidated Net Income, any extraordinary or non-recurring non-cash income. EBITDA shall be determined on a pro forma basis after giving effect to all Acquisitions made by the Company or any Subsidiary at any time during the applicable fiscal period, in each case as if such Acquisition had occurred at the beginning of such fiscal period.

3.7. FirstGuard Divestiture. The following definition is inserted in Section 1:

FirstGuard Divestiture means the sale, transfer, or contribution by the applicable Loan Parties of their right, title, and interest in and to the Capital Securities or assets of those Loan Parties obligated under the FirstGuard Health Plans on fair and reasonable terms and on an arm's length basis.

3.8. FirstGuard Health Plans. The following definition is inserted in Section 1:

FirstGuard Health Plans means the health plans managed by certain Loan Parties under contracts between certain Loan Parties and the States of Missouri and Kansas.

3.9. Loan Party. The definition of "Loan Party" in Section 1 is deleted in its entirety and replaced with the following:

Loan Party means the Company and each of its Subsidiaries (direct or indirect, whether now existing or hereafter created) separately, excluding any Dormant Subsidiary so long as it qualifies as a Dormant Subsidiary hereunder, but specifically including Centene Management Company LLC, a Wisconsin limited liability company, Centene Company of Texas, L.P., a Texas limited partnership, Managed Health Services Insurance Corp., a Wisconsin corporation, Superior HealthPlan, Inc., a Texas corporation, Coordinated Care Corporation Indiana, Inc., an Indiana corporation, MHS Consulting Corporation, a Wisconsin corporation, Bankers Reserve Life Insurance Company of Wisconsin, a Wisconsin insurance company, University Health Plans, Inc., a New Jersey corporation, CenCorp Consulting Company, Inc., a Delaware corporation, Buckeye Community Health Plan, Inc., an Ohio corporation, Centene Holdings LLC, a Delaware limited liability company, CCTX Holdings, LLC, a Delaware limited liability company, AirLogix, Inc., a Delaware corporation, FirstGuard, Inc., a Delaware corporation, FirstGuard Health Plan, Inc., a Missouri corporation, Peach State Health Plan, Inc., a Georgia corporation, CMC Real Estate Company, LLC, a Delaware limited liability company, Cenphiny Management, LLC, a Delaware limited liability company, NurseWise Holdings LLC, a Delaware limited liability company, NurseWise (SM) LP, a Delaware limited partnership, Cenpatico Behavioral Health, LLC, a California limited liability company, Cenpatico Behavioral Health of Texas, Inc., a Texas corporation, Desert Springs Professionals, LLC, an Arizona limited liability company, CBHSP Arizona, Inc., an Arizona corporation, Integrated Mental

Health Management, LLC, a Texas limited liability company, Integrated Mental Health Services, a Texas corporation, Cenpatico Behavioral Health Wisconsin, LLC, a Wisconsin limited liability company, Cenpatico Behavioral Health of Arizona, LLC, an Arizona limited liability company, Firstguard Health Plan Kansas, Inc., a Kansas corporation, Centene Plaza Redevelopment Corporation, a Missouri corporation, US Script, Inc., a Delaware corporation, LBB Industries, Inc., a Texas corporation, RX Direct, Inc., a Texas corporation, OptiCare Managed Vision, Inc., a Delaware corporation, Nurse Response, Inc., a Delaware corporation, Cardium Health Services Corp., a Delaware corporation, SilverSummit Healthplan, Inc., a Nevada corporation, Bridgeway Health Solutions LLC, a Delaware limited liability company, Bridgeway Health Solutions Arizona LLC, an Arizona limited liability company, OptiCare Vision Company, Inc., a Delaware corporation, Opticare Vision Insurance Company, Inc., a South Carolina corporation, Opticare IPA of New York, Inc., a New York corporation, Total Vision, Inc., a Delaware corporation, AECC Total Vision Health Plan of Texas, Inc., a Texas corporation, OcuCare Systems, Inc., a Florida corporation, and HealthSuite Partners, LLC, a Delaware limited liability company. The words "Loan Parties" refer to the Company and its now existing or hereafter created Subsidiaries (whether direct or indirect), excluding any Dormant Subsidiary so long as it qualifies as a Dormant Subsidiary hereunder, but specifically including each of the Persons specifically mentioned in the prior sentence, collectively. The Company agrees that any Subsidiary which is a Dormant Subsidiary will automatically become a Loan Party hereunder without any further action if at any time such Subsidiary ceases to be a Dormant Subsidiary.

3.10. Other Bank Documents. The following definition is inserted in Section 1:

Other Bank Documents means that certain Revolving Loan Agreement for $25,000,000 between CMC Real Estate Company, LLC and Regions Bank, N.A. dated as of May 22, 2006, that certain promissory note dated August 8, 2003 in the original principal amount of $8,000,000 executed by CMC Real Estate Company, LLC and payable to the order of Midwest BankCentre, that certain promissory note dated November 30, 2004 in the original principal amount of $5,500,000 executed by CMC Real Estate Company, LLC and payable to the order of Midwest BankCentre, and all instruments, documents, and agreements executed or delivered from time to time in connection therewith, in each case as amended, restated, supplemented or otherwise modified from time to time.

3.11. Required Capital. The definition of "Required Capital" in Section 1 is amended by replacing the figure "210%" with the figure "300%".

3.12. Revolving Commitment. The definition of "Revolving Commitment" in Section 1 is amended by replacing the figure "$200,000,000.00" with the figure "$300,000,000.00".

3.13. Term Indebtedness. The following definition is inserted in Section 1:

Term Indebtedness means the Debt of Company under any Term Indebtedness Documents from time to time.

3.14. Term Indebtedness Documents. The following definition is inserted in Section 1:

Term Indebtedness Documents means that certain indenture and/or other instruments, documents, and agreements to be executed or delivered from time to time in connection with any Term Indebtedness Transaction, in each case as amended, restated, supplemented or otherwise modified from time to time.

3.15. Term Indebtedness Transaction. The following definition is inserted in Section 1:

Term Indebtedness Transaction means any transaction pursuant to which Company publicly issues its bonds.

3.16. Termination Date. The definition of "Termination Date" in Section 1 is amended by replacing the date "September 9, 2010" with the date "September 21, 2011".

3.17. Increase in Revolving Commitment. Section 2.1.2 is amended by replacing the words "up to an aggregate amount not exceeding $75,000,000 (resulting in a maximum Revolving Commitment of $275,000,000)" in the first sentence with the words "up to an aggregate amount not exceeding $100,000,000 (resulting in a maximum Revolving Commitment of $400,000,000)".

3.18. L/C Commitment. Section 2.1.3 is amended by replacing the words "the aggregate Stated Amount of all Letters of Credit shall not at any time exceed $50,000,000" in clause (a) with the words "the aggregate Stated Amount of all Letters of Credit shall not at any time exceed $75,000,000".

3.19. Financial Condition. Section 9.4 is amended by replacing the dates "December 31, 2004" and "June 30, 2005" with the dates "December 31, 2005" and "June 30, 2006", respectively.

3.20. No Material Adverse Change. Section 9.5 is amended by replacing the date "December 31, 2004" with the date "December 31, 2005".

3.21. No Default. Section 9.22 is amended by inserting the following sentence at the end thereof: "No breach or default by Company has occurred with respect to any Term Indebtedness."

3.22. Capital Leases. Section 9.29 is amended by deleting the figure "$15,000,000" and replacing it with the words "the aggregate amount permitted with respect to Capital Leases permitted under Sections 11.1(i) and (j)."

3.23. Negative Pledges. Section 9.31 is deleted in its entirety and replaced with the following:

9.31 Negative Pledges. Except for the Loan Documents, the Other Bank Documents, the Centene Plaza Documents, and any Term Indebtedness Documents, no Loan Party is a party to or bound by any

contract, note, bond, indenture, deed, mortgage, deed of trust, security agreement, pledge, hypothecation agreement, assignment, or other agreement or undertaking, or any security, which prohibits the creation or existence of any Lien upon or assignment or conveyance of any of its assets.

3.24. Term Indebtedness Transaction and Term Indebtedness Documents. 10.1 is amended by inserting the following Section 10.1.12:

10.1.12 Term Indebtedness Documents. Promptly upon execution of any Term Indebtedness Documents, true and correct copies of all Term Indebtedness Documents (together with any amendments, restatements, supplements, or modifications thereto).

3.25. Debt. Section 11.1 is deleted in its entirety and replaced with the following:

11.1 Debt. Not, and not permit any other Loan Party to, create, incur, assume or suffer to exist any Debt, except:

(a) Obligations under this Agreement and the other Loan Documents;

(b) Debt of Loan Parties (including the Company) secured by Liens on real or personal property permitted by Section 11.2(d), and extensions, renewals and refinancings thereof; provided that the aggregate amount of all such Debt at any time outstanding shall not exceed $10,000,000;

(c) Debt of Loan Parties other than the Company (and which is non-recourse to the Company) secured only by Liens on real property permitted by Section 11.2(d), and extensions, renewals and refinancings thereof; provided, that the aggregate amount of all such Debt at any time outstanding shall not exceed $45,000,000;

(d) Debt (including any Term Indebtedness) which is unsecured provided that (i) the incurrence of such Debt (or Term Indebtedness) would not reasonably be expected to cause, either immediately or in the foreseeable future, a violation of the covenant contained in Section 11.14.2 and (ii) the documents governing such Debt (or any Term Indebtedness Documents in the case of any Term Indebtedness) do not contain covenants (including quantitative covenants and financial covenants) which are more restrictive than the covenants contained in this Agreement or which the Loan Parties could violate without violating the covenants contained in this Agreement;

(e) Subordinated Debt which is unsecured;

(f) Debt of Loan Parties the proceeds of which are used for the Centene Plaza Project, secured only by Liens permitted by Section 11.2(e), and extensions, renewals and refinancings thereof; provided, that (i) the aggregate amount of all such Debt at any time outstanding

shall not exceed $70,000,000, and (ii) the incurrence of such Debt would not reasonably be expected to cause, either immediately or in the foreseeable future, a violation of the covenant contained in Section 11.14.2

(g) Hedging Obligations approved by Administrative Agent and incurred in favor of a Lender or an Affiliate thereof for bona fide hedging purposes and not for speculation;

(h) Debt described on Schedule 11.1 and any extension, renewal or refinancing thereof so long as the principal amount thereof is not increased (it being agreed that any increase will be permitted without the consent of the Administrative Agent and the Required Lenders only to the extent that such additional Debt is otherwise permitted pursuant to clauses (b), (c), (d), (e), or (f) of this Section 11.1);

(i) Debt under intercompany Capital Leases, in which both lessor and lessee are Loan Parties, relating to any Loan Party's occupancy of office space within the complex known as Centene Plaza for capital assets whose aggregate cost if purchased would not exceed $70,000,000 (provided, that the aggregate Debt under clause (f) of this Section 11.1 and this clause (i) of this Section 11.1 which the Company would be required under GAAP to show on its consolidated balance sheet will not exceed $70,000,000);

(j) Debt under Capital Leases (excluding any Capital Leases permitted under clause (i) of this Section 11.1) for capital assets whose aggregate cost if purchased would not exceed $30,000,000;

(k) Indirect Obligations which do not exceed $2,000,000 in the aggregate at any time;

(l) Indirect Obligations arising with respect to customary indemnification obligations in favor of sellers in connection with Acquisitions permitted under Section 11.5 and purchasers in connection with dispositions permitted under Section 11.5;

(m) Indirect Obligations arising with respect to performance guaranties (which may include payment obligations) provided by a Loan Party on behalf of another Loan Party in the ordinary course of business; and

(n) Debt of any Loan Party to the Company which results from an Investment made by the Company in such Loan Party pursuant to, and permitted by, Section 11.11(b).

3.26. Liens. Section 11.2 is deleted in its entirety and replaced with the following:

11.2 Liens. Not, and not permit any other Loan Party to, create or permit to exist any Lien on any of its real or personal properties, assets

or rights of whatsoever nature (whether now owned or hereafter acquired), except:

(a) Liens for taxes or other governmental charges not at the time delinquent or thereafter payable without penalty or being contested in good faith by appropriate proceedings and, in each case, for which it maintains adequate reserves;

(b) Liens arising in the ordinary course of business (such as (i) Liens of landlords, carriers, warehousemen, mechanics and materialmen and other similar Liens imposed by law and (ii) Liens in the form of deposits or pledges incurred in connection with worker's compensation, unemployment compensation and other types of social security (excluding Liens arising under ERISA) or in connection with surety bonds, bids, performance bonds and similar obligations) for sums not overdue or being contested in good faith by appropriate proceedings and not involving any advances or borrowed money or the deferred purchase price of property or services and, in each case, for which it maintains adequate reserves;

(c) Liens described on Schedule 11.2 as of the Closing Date;

(d) (i) subject to the limitation set forth inSections 11.1(b) and (c), Liens that constitute purchase money security interests on any property (including mortgage liens on real property) securing debt incurred for the purpose of financing all or any part of the cost of acquiring such property, provided that any such Lien attaches to such property within 20 days of the acquisition thereof and attaches solely to the property so acquired; and (ii) subject to the limitation set forth in Section 11.1(i) and Section 11.1(j), Liens arising in connection with Capital Leases (and attaching only to the property being leased);

(e) Liens in the real property, fixtures, improvements, construction materials, surveys, plans, designs, specifications, construction contracts and architecture contracts relating to the Centene Plaza Project, together with any other assets of any Loan Party relating to such development and construction which customarily secure construction loans, which secure Debt permitted by Section 11.1(f);

(f) attachments, appeal bonds, judgments and other similar Liens, for sums not exceeding $5,000,000 arising in connection with court proceedings,provided the execution or other enforcement of such Liens is effectively stayed and the claims secured thereby are being actively contested in good faith and by appropriate proceedings;

(g) easements, rights of way, restrictions, minor defects or irregularities in title and other similar Liens not interfering in any material respect with the ordinary conduct of the business of any Loan Party;

(h) Liens arising under the Loan Documents; and

(i) the replacement, extension or renewal of any Lien permitted by clause (c) above upon or in the same property subject thereto arising out of the extension, renewal or replacement of the Debt secured thereby (without increase in the amount thereof).

3.27. Centene Plaza Divestiture and FirstGuard Divestiture. Section 11.5 is amended by inserting the words ", the Centene Plaza Divestiture, or the FirstGuard Divestiture" after the words "GPA Divestiture".

3.28. Inconsistent Agreements. Section 11.9 is amended by deleting clause (b) in its entirety and replacing it with the following: "(b) prohibit any Loan Party from granting a Lien on any of its assets to Administrative Agent and the Lenders (provided, however, that this clause (b) shall not be deemed to be violated by Company entering into any Term Indebtedness Documents, the Other Bank Documents, or the Centene Plaza Documents),".

3.29. Total Debt to EBITDA Ratio. Section 11.14.2 is deleted in its entirety and replaced with the following:

11.14.2 Total Debt to EBITDA Ratio. Not permit the Total Debt to EBITDA Ratio for any Computation Period ending prior to the incurrence of any Term Indebtedness or while any Term Indebtedness is not outstanding to exceed 2.75 to 1.00, and not permit the Total Debt to EBITDA Ratio for any other Computation Period to exceed 3.00 to 1.00.

3.30. Minimum Net Worth. Section 11.14.3 is deleted in its entirety and replaced with the following:

11.14.3 Minimum Net Worth. Not permit the Net Worth of the Company and its Subsidiaries to be less than $315,000,000 (the "Initial Required Net Worth Amount") as of June 30, 2006, or as of the end of each Fiscal Quarter to be less than an amount equal to the sum of $315,000,000 plus the sum of (a) an amount equal to 50% of Consolidated Net Income (without deduction for losses) on a cumulative basis from and after July 1, 2006, (b) an amount equal to 50% of the net proceeds (defined as gross proceeds less reasonable brokers' and underwriters' fees and commissions and other reasonable expenses of the issuance) of the issuance by Company or any other Loan Party of any Capital Securities on a cumulative basis from the Closing Date through the date of measurement, and (c) an amount equal to 50% of any increase in the Net Worth of the Company and its Subsidiaries associated with an Acquisition permitted by Section 11.5 on a cumulative basis from the Closing Date through the date of measurement, provided, that for purposes of this Section 11.14.3, Company's Net Worth shall be calculated net of the effect of any non-cash impairments taken related to the FirstGuard Health Plans and up to five percent (5%) of the Initial Required Net Worth Amount for any cash expenses related to exit costs for the FirstGuard Health Plans.

3.31. Guaranties. Section 11 is amended by inserting the following Section 11.21:

11.21 <u>Guaranties</u>. Not permit any Loan Party to deliver a guaranty in respect of any Term Indebtedness or otherwise become directly or indirectly liable for all or any part of any Term Indebtedness, and not permit any Loan Party to deliver a guaranty in respect of any other Debt or otherwise become directly or indirectly liable for all or any part of any other Debt, except for guaranties of Debt (other than any Term Indebtedness) permitted by <u>Section 11.1</u>.

3.32. Non-Payment of Other Debt. Section 13.1.2 is deleted in its entirety and replaced with the following:

13.1.2 <u>Default under Other Debt</u>. Any default shall occur under the terms applicable to any Debt of any Loan Party individually or in an aggregate amount (for all such Debt so affected and including undrawn committed or available amounts and amounts owing to all creditors under any combined or syndicated credit arrangement) exceeding $5,000,000, or under the terms applicable to any Term Indebtedness, and such default shall (a) consist of the failure to pay such Debt (including any Term Indebtedness) when due, whether by acceleration or otherwise, or (b) accelerate the maturity of such Debt (including any Term Indebtedness) or permit the holder or holders thereof, or any trustee or agent for such holder or holders, to cause such Debt (including any Term Indebtedness) to become due and payable (or require any Loan Party to purchase or redeem such Debt (including any Term Indebtedness) or post cash Collateral in respect thereof) prior to its expressed maturity.

3.33. Indemnification. Section 15.17 is amended by inserting the word ", PENALTIES" after the words "SUITS, LOSSES, LIABILITIES, DAMAGES".

3.34. Annex A. <u>Annex A</u> is deleted in its entirety and replaced with <u>Annex A</u> attached hereto.

3.35. Annex B. <u>Annex B</u> is deleted in its entirety and replaced with <u>Annex B</u> attached hereto.

3.36. Exhibit B. <u>Exhibit B</u> is deleted in its entirety and replaced with <u>Exhibit B</u> attached hereto.

3.37. Schedules. Schedules 9.8, 9.16, 9.17, and 11.11 are amended as described in <u>Exhibit C</u> attached hereto.

4. Representations and Warranties. Company hereby represents and warrants to Administrative Agent and each Lender that (i) this Amendment and each and every other document and instrument delivered by Company in connection with this Amendment (each, an Amendment Document and, collectively, the *Amendment Documents*) has been duly authorized by its Board of Directors, (ii) no consents are necessary from any third Person for its execution, delivery or performance of the Amendment Documents to which it is a party which have not been obtained and a copy thereof delivered to Administrative Agent, (iii) each of the Amendment Documents to which it is a party constitutes its legal, valid and binding obligation enforceable against it in accordance with its terms, except to the extent that the enforceability thereof against it may be limited by bankruptcy, insolvency, fraudulent conveyance, reorganization, moratorium or similar laws affecting the enforceability of creditors' rights generally or by equitable principles of general application (whether

considered in an action at law or in equity), (iv) all of the representations and warranties contained in the Loan Agreement, as amended hereby, are true and correct with the same force and effect as if made on and as of the effective date of this Amendment, except that with respect to the representations and warranties made regarding financial data, such representations and warranties are hereby made with respect to the most recent financial statements and other financial data (in the form required by the Original Loan Agreement) delivered by it to Administrative Agent, and (v) there exists no Unmatured Event of Default or Event of Default under the Original Loan Agreement.

5. Effect of Amendment. The execution, delivery and effectiveness of this Amendment shall not operate as a waiver of any right, power or remedy of Administrative Agent or the Lenders under the Original Loan Agreement or any of the other Loan Documents, nor constitute a waiver of any provision of the Original Loan Agreement or any of the other Loan Documents or any Unmatured Event of Default or Event of Default, nor act as a release or subordination of the Liens (if any) of Administrative Agent under the Loan Documents, except as expressly provided herein. Each reference in the Original Loan Agreement to *the Agreement*, *hereunder*, *hereof*, *herein*, or words of like import, shall be read as referring to the Original Loan Agreement as amended hereby. Each reference in the other Loan Documents to the *Loan Agreement* shall be read as referring to the Original Loan Agreement, as amended hereby.

6. Reaffirmation. Company hereby acknowledges and confirms that (i) except as expressly amended hereby, the Original Loan Agreement and other Loan Documents remain in full force and effect, (ii) the Loan Agreement, as amended hereby, is in full force and effect, (iii) it has no defenses to its obligations under the Loan Agreement or any of the other Loan Documents to which it is a party, (iv) the Liens of Administrative Agent under the Loan Documents (if any) continue in full force and effect and have the same priority as before this Amendment except as expressly provided herein, and (v) it has no claim against Administrative Agent or any Lender arising from or in connection with the Loan Agreement or the other Loan Documents.

7. Counterparts. This Amendment may be executed by the parties hereto on any number of separate counterparts, each of which shall be deemed an original, but all of which counterparts taken together shall constitute one and the same instrument. It shall not be necessary in making proof of this Amendment to produce or account for more than one counterpart signed by the party to be charged.

8. Counterpart Facsimile Execution. This Amendment, or a signature page thereto intended to be attached to a copy of this Amendment, signed and transmitted by electronic mail, facsimile machine or telecopier shall be deemed and treated as an original document. The signature of any Person thereon, for purposes hereof, is to be considered as an original signature, and the document transmitted is to be considered to have the same binding effect as an original signature on an original document. At the request of any party hereto, any electronic mail, facsimile or telecopy document is to be re-executed in original form by the Persons who executed the electronic mail, facsimile or telecopy document. No party hereto may raise the use of electronic mail, facsimile machine or telecopier or the fact that any signature was transmitted through the use of electronic mail or a facsimile or telecopier machine as a defense to the enforcement of this Amendment.

9. Governing Law. This Amendment and the rights and obligations of the parties hereunder shall be governed by and construed and interpreted in accordance with the internal laws of the State of Illinois applicable to contracts made and to be performed wholly within such state, without regard to choice or conflict of laws provisions.

10. Section Titles. The section titles in this Amendment are for convenience of reference only and shall not be construed so as to modify any provisions of this Amendment.

11. Incorporation By Reference. Administrative Agent, the Lenders, and Company hereby agree that all of the terms of the Loan Documents are incorporated in and made a part of this Amendment by this reference.

12. New Titles. Wachovia Bank, National Association is hereby given the title of "Syndication Agent" under the Loan Agreement and the Loan Documents. Nothing contained in the foregoing sentence shall give Wachovia Bank, National Association any additional rights or obligations under the Loan Agreement or the Loan Documents. The title of "Co-Syndication Agent" is hereby removed from National City Bank and Wachovia Bank, National Association.

13. Statutory Notice — Oral Commitments. Nothing contained in such notice shall be deemed to limit or modify the terms of the Loan Documents or this Amendment:

ORAL AGREEMENTS OR COMMITMENTS TO LOAN MONEY, EXTEND CREDIT OR TO FORBEAR FROM ENFORCING REPAYMENT OF A DEBT INCLUDING PROMISES TO EXTEND OR RENEW SUCH DEBT ARE NOT ENFORCEABLE. TO PROTECT YOU (COMPANY) AND US (CREDITOR) FROM MISUNDERSTANDING OR DISAPPOINTMENT, ANY AGREEMENTS WE REACH COVERING SUCH MATTERS ARE CONTAINED IN THIS WRITING, WHICH IS THE COMPLETE AND EXCLUSIVE STATEMENT OF THE AGREEMENT BETWEEN US, EXCEPT AS WE MAY LATER AGREE IN WRITING TO MODIFY IT.

COMPANY ACKNOWLEDGES THAT THERE ARE NO OTHER AGREEMENTS BETWEEN ADMINISTRATIVE AGENT OR ANY LENDER AND COMPANY, ORAL OR WRITTEN, CONCERNING THE SUBJECT MATTER OF THE LOAN DOCUMENTS, AND THAT ALL PRIOR AGREEMENTS CONCERNING THE SAME SUBJECT MATTER, INCLUDING ANY PROPOSAL, TERM SHEET OR LETTER, ARE MERGED INTO THE LOAN DOCUMENTS AND THEREBY EXTINGUISHED.

{remainder of page intentionally left blank}

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by appropriate duly authorized officers as of the date first above written.

Company:

CENTENE CORPORATION

By: /s/ J. Per Brodin
Name: J. Per Brodin
Title: SrVP & CFO

Administrative Agent:

LASALLE BANK NATIONAL ASSOCIATION

By: /s/ Sam L. Dendrinos
Name: Sam L. Dendrinos
Title: First Vice President

Lenders:

LASALLE BANK NATIONAL ASSOCIATION

By: /s/ Sam L. Dendrinos
Name: Sam L. Dendrinos
Title: First Vice President

WACHOVIA BANK, NATIONAL ASSOCIATION

By: /s/ Jeanette A. Griffin
Name: Jeanette A. Griffin
Title: Director

NATIONAL CITY BANK (formerly National City Bank of the Midwest)

By: /s/ Heather Hinkelman
Name: Heather Hinkelman
Title: Banking Officer

SUNTRUST BANK

By: /s/ John W. Teasley
Name: John W. Teasley
Title: Director

REGIONS BANK

By: /s/ Anne D. Silvestri
Name: Anne D. Silvestri
Title: SVP

MERRILL LYNCH CAPITAL CORPORATION

By: /s/ John C. Rowland
Name: John C. Rowland
Title: Vice President

ANNEX A

LENDERS AND PRO RATA SHARES

Lender	Revolving Commitment Amount	Pro Rata Share
LaSalle Bank National Association	$ 90,000,000.00	30.000000000%
Wachovia Bank, National Association	$ 65,000,000.00	21.666666667%
National City Bank	$ 35,000,000.00	11.666666667%
SunTrust Bank	$ 35,000,000.00	11.666666667%
Regions Bank	$ 35,000,000.00	11.666666667%
Merrill Lynch Capital Corporation	$ 40,000,000.00	13.333333333%
TOTALS	$ 300,000,000.00	100.000000000%

ANNEX B

ADDRESSES FOR NOTICES

CENTENE CORPORATION

7711 Carondelet Avenue, Suite 800
Clayton, Missouri 63105
Attention: J. Per Brodin, Chief Financial Officer
Telephone: 314-725-4477
Facsimile: 314-725-5180

LASALLE BANK NATIONAL ASSOCIATION, as Administrative Agent, Co-Lead Arranger, Issuing Lender and a Lender

Notices of Borrowing , Conversion, and Continuation

135 South LaSalle Street
Chicago, Illinois 60603
Attention: Israel Balaguer
Telephone: (312) 992-2843
Facsimile: (312) 904-4448

Notices of Letter of Credit Issuance

135 South LaSalle Street
Chicago, Illinois 60603
Attention: Bryen Zimmerman
Telephone: (312) 904-7745
Facsimile: (312) 904-6303

All Other Notices

135 South LaSalle Street
Chicago, Illinois 60603
Attention: Sam L. Dendrinos
Telephone: (312) 904-8101
Facsimile: (312) 904-4364

WACHOVIA BANK, NATIONAL ASSOCIATION, as Syndication Agent, Co-Lead Arranger, and a Lender

301 South College Street
Charlotte, North Carolina 28288
Attention: James Hill
Telephone: (704) 383-6234
Facsimile: (704) 383-7992

With a copy to:
1 S. Broad Street, PA4152
Philadelphia, Pennsylvania 19107
Jeanette Griffin
Telephone: (267) 321-6615
Facsimile: (267) 321-6700

NATIONAL CITY BANK, as a Lender

120 S. Central Avenue
Locator 56-SLWB08
Clayton, Missouri 63105
Attention: S. Farris Tzinberg
Telephone: (314) 898-1215
Facsimile: (314) 898-1401

SUNTRUST BANK, as a Lender

201 4th Avenue, North
Nashville, Tennessee 37219
Attention: William Priester
Telephone: (615) 748-5969
Facsimile: (615) 748-5269

REGIONS BANK, as a Lender

8182 Maryland Avenue
St. Louis, Missouri 63105
Attention: Anne Silvestri
Telephone: (314) 615-2372
Facsimile: (314) 615-2355

MERRILL LYNCH CAPITAL CORPORATION, as a Lender

4 World Financial Center (22nd Floor)
New York, New York 10080
Attention: John Rowland
Telephone: (212) 449-1351
Facsimile: (212) 738-1186

Exhibit A
Documents and Requirements

1. Revolving Notes:
   a. LaSalle Bank National Association ($90,000,000.00)
   b. Wachovia Bank, National Association ($65,000,000.00)
   c. National City Bank ($35,000,000.00)
   d. SunTrust Bank ($35,000,000.00)
   e. Regions Bank ($35,000,000.00)
   f. Merrill Lynch Capital Corporation ($40,000,000.00)
2. Closing Certificate
3. Master Assignment and Acceptance Agreement
4. Agent Fee Letter
5. Current insurance certificates for Company and each Loan Party evidencing that Company and each Loan Party has in force insurance meeting the applicable requirements of the Credit Agreement
6. UCC Searches for Company with Delaware Secretary of State
7. Secretary's Certificate of Company (certifying resolutions, Certificate of Incorporation, By-laws and Incumbency)
8. Organizational chart, certified by Company as true, correct, and complete
9. Good Standing Certificates for Company from the Secretaries of State of Missouri and Delaware.
10. Legal Opinion of Company's counsel
11. Such other documents, reports and information as Administrative Agent or Administrative Agent's counsel deems reasonable and necessary
12. Payment of Administrative Agent's costs and expenses (including payment of Lewis, Rice & Fingersh invoice) and payment of all fees due Administrative Agent and the Lenders under the Agent Fee Letter.

Exhibit B
Compliance Certificate

FORM OF COMPLIANCE CERTIFICATE

To: LaSalle Bank National Association, as Administrative Agent

Please refer to the Credit Agreement dated as of September 14, 2004 (as amended, restated, supplemented or otherwise modified from time to time, the "Credit Agreement") among Centene Corporation (the "Company"), various financial institutions and LaSalle Bank National Association, as Administrative Agent. Terms used but not otherwise defined herein are used herein as defined in the Credit Agreement.

I. Reports. A copy of the **[annual audited/quarterly]** report of the Company as at ___, ___(the "Computation Date"), which report fairly presents in all material respects the financial condition and results of operations **[(subject to the absence of footnotes and to normal year-end adjustments)]** of the Company as of the Computation Date and has been prepared in accordance with GAAP consistently applied **[is enclosed herewith][may be found at the Company's website at www.centene.com]**.

II. Financial Tests. The Company hereby certifies and warrants to Administrative Agent, Issuing Lender and each Lender that the following is a true and correct computation as at the Computation Date of the following ratios and/or financial restrictions contained in the Credit Agreement and each of the enclosed are true and correct as at the Computation Date:

A. Section 11.14.1 — Minimum Fixed Charge Coverage Ratio

1. EBITDA

a.	Consolidated Net Income	$__________
b.	cash Interest Expense	$__________
c.	income tax expense	$__________
d.	depreciation expense	$__________
e.	amortization expense	$__________
f.	other non-cash expenses (see definition)	$__________
g.	minus non-cash income (see definition)	$__________
h.	pro forma EBITDA from Acquisitions (without duplication of above)	$__________
i.	EBITDA (sum of a, b, c, d, e, f, and h, minus g)	$__________

2. income taxes paid $__________

3. unfinanced Capital Expenditures $___________

4. cash dividends paid $___________

5. sum of (2), (3),and (4) $___________

6. remainder of (1)(i) minus (5) $___________

7. cash Interest Expense $___________

8. required payments of principal of Funded Debt (excluding Revolving Loans) $___________

9. sum of (7) and (8) $___________

10. ratio of (6) to (9) _______ to 1

11. minimum required 1.75 to 1

B. Section 11.14.2 - Maximum Total Debt to EBITDA Ratio

1. Total Debt $___________

2. EBITDA (from (A)(1)(i) above) $___________

3. ratio of (1) to (2) _______to 1

4. maximum allowed 2.75 to 1 or 3.00 to 1 (as applicable)

C Section 11.14.3 — Minimum Net Worth

1. Net Worth $___________

2. minimum required Net Worth

a. base amount $315,000,000

b. 50% of cumulative Consolidated Net Income since 7/1/06 $___________

c. 50% of net proceeds from issuance of Capital Securities $___________

d. 50% of net proceeds from increases in Net Worth attributable to Acquisitions $___________

e. minimum required Net Worth (sum of a, b, c, and d) $___________]

The Company further certifies to you that no Event of Default or Unmatured Event of Default has occurred and is continuing.

The Company has caused this Certificate to be executed and delivered by its duly authorized officer on ___, ___.

CENTENE CORPORATION

By: ______________________________

Title: ______________________________

Exhibit 10.2

Contract Amendment for Medicaid and BadgerCare Services
Managed Health Services

The agreement entered into for the period of February 1, 2006 through December 31, 2007, between the State of Wisconsin acting by or through the Department of Health and Family Services, hereinafter referred to as the "Department" and Managed Health Services, an insurer with a certificate of authority to do business in Wisconsin for the Medicaid and BadgerCare Managed Care Program is hereby amended as follows:

1. Article III, B. Compliance with Applicable Federal Law

   After the first paragraph, add the following paragraph:
   "Federal funds cannot be used for lobbying. Specifically and as applicable, the Contractor agrees to abide by the Copeland Anti-Kickback Act, the Davis-Bacon Act, federal contract work hours and safety standards requirements, the Federal Clean Air Act and the Federal Water Pollution Control Act.

2. Article VI, K, Incentive for Expansion

   Change "compared to enrollment numbers shown on the January 2006 MMIS" to "compared to the average BadgerCare enrollment shown on the February through April 2006 MMIS"

   Delete the last sentence. Add the following:

   a. An incentive payment is available to all plans that remove or increase current enrollment caps in the following service areas and/or enter the following service areas resulting in increased BadgerCare enrollment.

      1 — Duluth-Superior
      2 — Wausau-Rhinelander
      3 — Green Bay
      4 — Twin Cities
      5 — Stevens Point – Marshfield
      7 — LaCrosse
      8 — South Central WI/Madison
      11 — Dane County

   b. The incentive payment will not become part of the base rate.

   c. An HMO that accepts the incentive proposal cannot lower the enrollment limit or entirely leave a rate region prior to July 1, 2008 without prior approval from the Department. An HMO that chooses to

impose lower enrollment caps or leave a rate region is not eligible for an incentive payment and any previous incentive payments will be recouped.

d. The incentive payment will be made for BadgerCare enrollment for State Fiscal Year 2007 only. BadgerCare enrollment is defined as recipients in medical status codes Bl, B2, B3, B4, B5, B6 and GP and enrolled in a Health Maintenance Organization.

e. An average BadgerCare capitation rate, specific to each HMO, will be calculated using the actual payments made during the enrollment period February 2006 to April 2006.

f. The amount of the incentive payment per enrollment month will be 7.0% of the average BadgerCare capitation payment as described in # 5.

g. The percentage growth in eligibility will be determined by dividing the average monthly enrollment for the entire HMO rate region in BadgerCare medical status codes (B1, B2, B3, B4, B5, B6 and GP) during the incentive period by the average monthly BadgerCare enrollment for the entire rate region in the base period (February 2006 through April 2006). There will be two incentive periods: One from July, 2006 through December, 2006 and the other from January, 2007 through June, 2007.

h. The total incentive payment, for each incentive period, will be calculated by the following method:

   i. First by determining the adjusted enrollment during the base period. This is calculated by using the HMO's average monthly enrollment during the base period and multiplying this by the growth in eligibility (see "g").

   ii. Next, this amount will be subtracted from the HMO's average monthly enrollment during the incentive period.

   ii. If this number is greater than zero, it will be multiplied by the number of months in the incentive period (six months) and then multiplied by the incentive payment amount (see "e").

i. The payment will be made by March 1, 2007 for the July through December 2006 incentive period and prior to July 31, 2007 for the January through June 2007 incentive period.

j. Should an HMO cease doing business in the state, the HMO will be paid for that portion of the incentive period that they were doing business in the targeted rate region(s).

---

k. An example of the incentive payment is shown below:

Determine Actual Enrollment:

Base period enrollment = 700 of the county's 1,000 total eligibles are enrolled (70%):

HMO A = 20% of total county enrollment or 140 enrollees
HMO B = 45% of total county enrollment or 315 enrollees
HMO C = 35% of total county enrollment or 245 enrollees

The average monthly enrollment for the incentive period = 960 of 1,200 eligibles (80%):

HMO A = 25% of total county enrollment or 240 enrollees
HMO B = 40% of total county enrollment or 384 enrollees
HMO C = 35% of total county enrollment or 336 enrollees

Factor out eligibility growth & determine average enrollment above base enrollment:

Because eligibility growth is 20%, the average enrollment months for the incentive period are:

HMO A = 240 – (120% x 140) = 72 enrollees
HMO B = 384 – (120% x 315) = 6 enrollees
HMO C = 336 - (120% x 245) = 42 enrollees
Totals 960 - 840 = 120 enrollees

Enrollment above base enrollment & adjusted for growth =120 enrollees.

Calculate incentive amount for the incentive period:

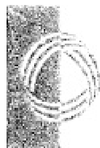
The incentive payment assuming 7% of the average cap rate is $11.00 would be:

Total Incentive pool = 960 - 840 = 120 x 6 months x $11 = $7,920.

HMO A = 72 enrollment months x 6 months x $11 = $4,752.00
HMO B = 6 enrollment months x 6 months x $11 = $396.00
HMO C = 42 enrollment months x 6 months x $11 = $2,772.00
Total Payout $7,920.00

All terms and conditions of the February 1, 2006 through December 31, 2007 contract and any prior amendments that are not affected by this amendment shall remain in full force and effect through the extension period.

Managed Health Services	**Department of Health and Family Services**
Official Signature	Official Signature
/s/ Linda McKnew	
Printed Name	Printed Name
Linda McKnew	Cheryl McIlquham
Title	Title
President and CEO	Interim Administrator Division of Health Care Financing
Date	Date
8-22-06	



Georgia Department of
Community Health

Rhonda M. Medows, MD, Commissioner *Sonny Perdue, Governor*

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

July 10, 2006

Sent Via: Certified Mail / Return Receipt Requested

David McNichols
Peachstate Health Plan, Inc.
3200 Highland Pkwy., SE
Suite 300
Smyrna, GA 30082

RE: NOTICE OF RENEWAL FOR FISCAL YEAR 2007
Contract# 0653

Dear Mr. McNichols:

This letter serves as written notice that the Department of Community Health (hereinafter "DCH" or the "Department") is exercising its option to renew the above-referenced contract for an additional State fiscal year, subject to the terms and conditions of the underlying contract (the "Contract") and any applicable subsequent amendments. The Contract, as renewed, shall terminate on **June 30, 2007.** All terms and conditions of the contract, including reimbursement, shall remain as stated in the original contract and any amendments thereto.

In addition, below is a list of items necessary to update your contract information. It is essential that this information is provided as soon as possible, but no later than September 1, 2006. If you are unable to respond in that time, please notify us by written correspondence (email is acceptable). Please review your current contract and send the following documents **if applicable:**

- Certificate of Insurance;
- Payment and/or Performance Bonds;
- Top-level management names, titles, areas of responsibility and resumes;
- Organizational Chart;
- The names, titles, areas of responsibility, and resumes for all employees assigned to perform work on the contract during fiscal year 2007;
- The names, titles, areas of responsibility, and resumes for all employees anticipated to perform work on the contract during fiscal year 2007;
- The names and business addresses of all subcontractors performing work on the Contract during fiscal year 2007;

- The names and business addresses of all subcontractors anticipated to perform work on the Contract during fiscal year 2007;
- A copy of your last audit report from an independent Certified Public Accountant firm for the period covering Fiscal Year 2006, if available, or the last conducted audit report; and
- A copy of your business continuity plan or similar document (optional).

Enclosed is an additional copy of this letter. Please sign both copies where indicated retaining one for your files and returning the other via fax and mail before close of business June 30, 2006 to:

Georgia Department of Community Health
Contracts Administration
2 Peachtree Street, NW, 40th Floor
Atlanta, Georgia 30303-3159
Fax: (404) 463-5025

Please contact me at (404) 463-1930 or via email at bshepard@dch.ga.gov should you have any questions or require additional information. We look forward to continuing with your contract in Fiscal Year 2007.

Sincerely,

/s/ Joanne Mitchell
Joanne Mitchell
Contract Manager

CC: Charemon Grant, Esq. General Counsel File

Signature of Acceptance:

We, PEACH STATE HEALTH PLAN, do hereby acknowledge the renewal of our contract, Contract #0653 agree to the renewal terms as heretofore stated by the duly authorized signature below:

/s/ David McNichols
Authorized Signature
PRESIDENT, CEO

7/26/2006
Date

Exhibit 12.1

Centene Corporation
Computation of ratio of earnings to fixed charges
($ in thousands)

	For the Nine Months Ended 09/30/06	Year ended December 31, 2005	2004	2003	2002	2001
Earnings:						
Pre-tax earnings from continuing operations	$ (43,134)	$ 85,856	$ 70,287	$ 51,893	$ 41,136	$ 22,026
Addback:						
Fixed charges	10,273	6,506	2,489	1,232	915	1,058
Total earnings	$ (32,861)	$ 92,362	$ 72,776	$ 53,125	$ 42,051	$ 23,084
Fixed Charges:						
Interest expense	$ 7,536	$ 3,990	$ 680	$ 194	$ 45	$ 362
Interest component of rental payments (1)	2,737	2,516	1,809	1,038	870	696
Total fixed charges	$ 10,273	$ 6,506	$ 2,489	$ 1,232	$ 915	$ 1,058
Ratio of earnings to fixed charges	(3.20)	14.20	29.24	43.12	45.96	21.82
Dollar amount of deficiency	$ 43,134	—	—	—	—	—

(1) Estimated at 33% of rental expense as a reasonable approximation of the interest factor.

EXHIBIT 31.1

CERTIFICATION

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 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 period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this quarterly report is being prepared;
   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent function):
   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: October 24, 2006

/s/ Michael F. Neidorff
Michael F. Neidorff
Chairman and Chief Executive Officer
(principal executive officer)

EXHIBIT 31.2

CERTIFICATION

I, J. Per Brodin certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Centene Corporation;
2. Based on my knowledge, this 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 period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this quarterly report is being prepared;
   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent function):
   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: October 24, 2006

/s/ J. Per Brodin
J. Per Brodin
Senior Vice President, Chief Financial Officer,
Secretary and Treasurer
(principal financial and accounting officer)

EXHIBIT 32.1

**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 September 30, 2006, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), the undersigned, Michael F. Neidorff, Chairman 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.

/s/ Michael F. Neidorff
Michael F. Neidorff
Chairman and Chief Executive Officer
(principal executive officer)

Dated: October 24, 2006

EXHIBIT 32.2

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 September 30, 2006, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), the undersigned, J. Per Brodin, Senior Vice President, Chief Financial Officer, Secretary 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.

/s/ J. Per Brodin
J. Per Brodin
Senior Vice President, Chief Financial Officer,
Secretary and Treasurer
(principal financial and accounting officer)

Dated: October 24, 2006