SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

[X] QUARTERLY REPORT UNDER SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934 for the quarterly period ended June 30, 2002

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 No. 000-33395

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

Delaware	04-1406317
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

7711 Carondelet Avenue, Suite 800
St. Louis, Missouri
(Address of principal executive offices)

63105
(Zip Code)

314-725-4477
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.

X YES NO

As of July 19, 2002, registrant had 10,638,207 shares of common stock, $.001 par value per share, outstanding.

CENTENE CORPORATION

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PART I. FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS
(In thousands, except share data)

<TABLE>
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	June 30, 2002	December 31, 2001
	(Unaudited)	
ASSETS		
<S>	<C>	<C>
CURRENT ASSETS:		
Cash and cash equivalents	$ 44,336	$ 88,867
Premium and related receivables, net of allowances of $3,164 and $3,879, respectively	7,524	7,032
Short-term investments, at fair value (amortized cost $6,135 and $1,166, respectively)	6,132	1,169
Deferred income taxes	3,424	2,515
Other current assets	4,215	2,464
Total current assets	65,631	102,047
LONG-TERM INVESTMENTS, at fair value (amortized cost $78,390 and $22,127, respectively)	78,752	22,339
PROPERTY AND EQUIPMENT, net	5,395	3,796
INTANGIBLE ASSETS, net	2,732	2,396
DEFERRED INCOME TAXES	382	788
OTHER ASSETS	4,844	--
Total assets	$157,736	$131,366
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES:		
Medical claims liabilities	$ 63,557	$ 59,565
Accounts payable and accrued expenses	5,141	7,712
Total current liabilities	68,698	67,277
OTHER LIABILITIES	4,738	--
Total liabilities	73,436	67,277
STOCKHOLDERS' EQUITY:		
Common stock, $.001 par value; authorized 40,000,000 shares; 10,638,207 and 10,085,112 shares issued and outstanding	11	10
Additional paid-in capital	71,443	60,857
Net unrealized gain on investments, net of tax	226	135
Retained earnings	12,620	3,087
Total stockholders' equity	84,300	64,089
Total liabilities and stockholders' equity	$157,736	$131,366

</TABLE>

The accompanying notes are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES

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

<TABLE>
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	Three Months Ended June 30,		Six Months Ended June 30,	
	2002	2001	2002	2001
	(Unaudited)		(Unaudited)	

<S>	<C>	<C>	<C>	<C>
REVENUES:				
Premiums	$ 107,503	$ 80,458	$ 203,152	$ 150,682
Administrative services fees	107	102	211	182
Total revenues	107,610	80,560	203,363	150,864
EXPENSES:				
Medical services costs	88,109	66,466	167,053	125,039
General and administrative expenses	11,783	9,581	22,330	18,406
Total operating expenses	99,892	76,047	189,383	143,445
Earnings from operations	7,718	4,513	13,980	7,419
OTHER INCOME (EXPENSE):				
Investment and other income, net	976	931	1,891	1,897
Interest expense	(11)	(101)	(11)	(196)
Earnings before income taxes	8,683	5,343	15,860	9,120
INCOME TAX EXPENSE	3,449	2,113	6,327	3,708
Net earnings	5,234	3,230	9,533	5,412
ACCRETION OF REDEEMABLE PREFERED STOCK	--	(123)	--	(246)
Net earnings attributable to common stockholders	$ 5,234	$ 3,107	$ 9,533	$ 5,166
EARNINGS PER COMMON SHARE, BASIC:				
Net earnings per common share	$ 0.51	$ 3.41	$ 0.93	$ 5.68
EARNINGS PER COMMON SHARE, DILUTED:				
Net earnings per common share	$ 0.45	$ 0.42	$ 0.83	$ 0.70
SHARES USED IN COMPUTING PER SHARE AMOUNTS:				
Basic	10,322,610	911,636	10,207,618	908,907
Diluted	11,546,379	7,738,742	11,435,183	7,748,825

</TABLE>

The accompanying notes are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)

<TABLE>
<CAPTION>

	Six Months Ended June 30,	
	2002	2001

	(Unaudited)	
<S>	<C>	<C>
CASH FLOWS FROM OPERATING ACTIVITIES:		
Net earnings	$ 9,533	$ 5,412
Adjustments to reconcile net earnings to net cash provided by operating activities -		
Depreciation and amortization	975	631
Stock compensation expense	49	6
Gain on sale of investments	(307)	(49)
Changes in assets and liabilities -		
(Increase) decrease in premium and related receivables	(492)	10,882
(Increase) decrease in other current assets	(1,676)	2,104
(Increase) decrease in deferred income taxes	(555)	925
Increase in other assets	(106)	--
Increase in medical claims liabilities	3,992	2,784
(Decrease) increase in accounts payable and accrued expenses	(2,497)	5,299
Net cash provided by operating activities	8,916	27,994
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchase of property and equipment	(2,431)	(1,793)
Purchase of investments	(87,328)	(15,918)
Sales and maturities of investments	29,093	10,455
Contract acquisitions	--	(1,000)
Investment in subsidiary	(3,193)	7,701
Net cash used in investing activities	(63,859)	(555)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Net proceeds from issuance of common stock	10,304	--
Proceeds from exercise of stock options	108	17
Net cash provided by financing activities	10,412	17
Net (decrease) increase in cash and cash equivalents	(44,531)	27,456
CASH AND CASH EQUIVALENTS, beginning of period	88,867	19,023
CASH AND CASH EQUIVALENTS, end of period	$ 44,336	$ 46,479
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION:		
Interest paid	$ --	$ 439
Income taxes paid	$ 9,282	$ 1,758

The Company purchased all of the capital stock of Bankers Reserve for $3,527 (Note 3). In conjunction with the acquisition, liabilities were assumed as follows:

Fair value of assets acquired	$ 8,719
Cash paid for the capital stock	(3,527)
Liabilities assumed	$ 5,192

</TABLE>

The accompanying notes are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES

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

1. Organization

Centene Corporation (Centene or the Company) provides managed care programs and related services to individuals receiving benefits under Medicaid, including Supplemental Security Income (SSI), and Children's Health Insurance Program (CHIP). Centene operates under its own state licenses in Wisconsin, Indiana and Texas, and contracts with other managed care organizations to provide risk and nonrisk management services.

2. Basis of Presentation

The unaudited financial statements herein have been prepared by the Company pursuant to the rules and regulations of the Securities and Exchange Commission. The accompanying interim financial statements have been prepared under the presumption that users of the interim financial information have either read or have access to the audited financial statements for the latest fiscal year ended December 31, 2001. Accordingly, footnote disclosures which would substantially duplicate the disclosures contained in the December 31, 2001 audited financial statements have been omitted from these interim financial statements. In the

(In thousands, except share data)

opinion of management, these financial statements reflect all adjustments, consisting only of normal recurring adjustments, which are necessary for a fair presentation of the results of the interim periods presented.

3. Acquisition of Bankers Reserve

On March 14, 2002, the Company completed an acquisition of Bankers Reserve Life Insurance Company of Wisconsin (Bankers Reserve) for a cash purchase price of $3,500. The Company accounted for this acquisition under the purchase method of accounting and accordingly, the consolidated results of operations include the results of the acquired Bankers Reserve business from the date of acquisition. The Company has excluded pro forma disclosures related to the impact of Bankers Reserve on the results of operations for the six-month period ended June 30, 2002, as well as the comparable period in the preceding year. Such disclosures have been excluded as there are no significant continuing operations as of the date of acquisition, outside of the run-off of Separate Account activity.

The Company allocated the purchase price to net tangible and identifiable intangible assets based on their fair value. Centene allocated $479 to identifiable intangible assets, representing the value assigned to acquired licenses, which are being amortized on a straight-line basis over a period of 10 years. In addition, as part of the Bankers Reserve acquisition, $5,200 of Separate Account assets and $5,200 of Separate Account liabilities were acquired and recorded in Other Assets and Other Liabilities. The separate account balances are being liquidated and paid to individual insureds as the annuities mature.

Centene plans to use Bankers Reserve as a reinsurance company for its existing managed care Medicaid entities. It is not currently anticipated that Bankers Reserve would be used to offer reinsurance to unaffiliated entities.

4. Recently Issued Accounting Pronouncements

In July 2001, SFAS No. 142, "Goodwill and Other Intangible Assets," was issued which requires that goodwill and intangible assets with indefinite useful lives no longer be amortized, but instead tested at least annually for impairment. The Company has adopted SFAS No. 142 effective January 1, 2002. Goodwill amortization has been discontinued. For the three months ended June 30, 2001, this adjustment would have added $122 in net earnings, or $0.02 per diluted share and $0.13 per basic share. For the six months ended June 30, 2001, this adjustment would have added $245 in net earnings, or $0.03 per diluted share and $0.27 per basic share. The Company reviews goodwill and other long-lived assets annually for impairment and recognizes impairment losses if expected undiscounted future cash flows of the related assets are less than their carrying value. An impairment loss represents the amount by which the carrying value of an asset exceeds the fair value of the asset. The Company did not recognize any impairment losses for the periods presented.

In August 2001, the FASB issued SFAS No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets." SFAS No. 144 provides updated guidance concerning the recognition and measurement of an impairment loss for certain types of long-lived assets. It also expands the scope of a discontinued operation to include a component of an entity. SFAS No. 144 is effective for financial statements issued for fiscal years beginning after December 15, 2001, and interim periods within those years. The adoption of the provisions of SFAS No. 144 did not have a material impact on the Company's results of operations, financial position or cash flows.

5. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per common share for the three months ended June 30:

<TABLE>
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	2002	2001
<S>	<C>	<C>
Net earnings	$ 5,234	$ 3,230
Accretion of redeemable preferred stock	--	(123)
Net earnings attributable to common stockholders	$ 5,234	$ 3,107

Shares used in computing per share amounts:
Weighted average number of common shares

(In thousands, except share data)

outstanding	10,322,610	911,636
Dilutive effect of stock options and warrants (as determined by applying the treasury stock method) and convertible preferred stock	1,223,769	6,827,106
Weighted average number of common shares and potential dilutive common shares outstanding	11,546,379	7,738,742
EARNINGS PER COMMON SHARE, BASIC:		
Net earnings per common share	$ 0.51	$ 3.41
EARNINGS PER COMMON SHARE, DILUTED:		
Net earnings per common share	$ 0.45	$ 0.42

The following table sets forth the calculation of basic and diluted net earnings per common share for the six months ended June 30:

	2002	2001
Net earnings	$ 9,533	$ 5,412
Accretion of redeemable preferred stock	--	(246)
Net earnings attributable to common stockholders	$ 9,533	$ 5,166
Shares used in computing per share amounts:		
Weighted average number of common shares outstanding	10,207,618	908,907
Dilutive effect of stock options and warrants (as determined by applying the treasury stock method) and convertible preferred stock	1,227,565	6,839,918
Weighted average number of common shares and potential dilutive common shares outstanding	11,435,183	7,748,825
EARNINGS PER COMMON SHARE, BASIC:		
Net earnings per common share	$ 0.93	$ 5.68
EARNINGS PER COMMON SHARE, DILUTED:		
Net earnings per common share	$ 0.83	$ 0.70

6. Legal Proceedings

From 1998 to 2000, Centene provided Medicaid services in certain regions of Indiana as subcontractor with Maxicare, Indiana, Inc. In June 2001, the Insurance Commissioner of the Indiana Department of Insurance declared Maxicare insolvent and ordered Maxicare into liquidation. In September 2001, Centene filed an adversary proceeding in Marion County Circuit Court against Maxicare and the Indiana Insurance Commissioner seeking declaratory and injunctive relief and the turnover of funds. This proceeding is based on Centene's belief that the State of Indiana's proposed liquidation plan for Maxicare does not adequately address Centene's claims for approximately $4,700 that Centene believes is owed to it by Maxicare. Maxicare and the Indiana Insurance Commissioner subsequently filed a counterclaim suit against Centene seeking, among other things, to avoid any claims Centene has for funds held by Maxicare and to recover payments previously made to Centene by Maxicare in the amount of approximately $2,000, on the grounds those payments constituted preferential transfers. A bench trial is scheduled for July 26, 2002.

7. Subsequent Event

During July 2002, the Board of Directors of United SPC, a captive insurance company in which Centene maintained an investment, declared a one-time dividend of $5,055. The dividend, which was received on July 18, 2002, related to underwriting gains on certain underlying books of business assumed by United SPC.

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes appearing elsewhere in this report and in our annual report for the year ended December 31, 2001. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth below under "Factors that may Affect Future Results and the Trading Price of Our Common Stock." Our results of operations and projections of future earnings depend in large part on accurately predicting and effectively managing health benefits and other operating expenses.

OVERVIEW

We provide managed care programs and related services to individuals receiving benefits under Medicaid, including Supplemental Security Income or SSI, and the Children's Health Insurance Program or CHIP. We have health plans in Wisconsin, Indiana and Texas.

On June 20, 2002, we announced that our subsidiary Superior HealthPlan had signed a definitive agreement with Texas Universities Health Plan to purchase the CHIP contract in the San Antonio, El Paso, and Amarillo and Lubbock, Texas service areas covering 26,000 children's lives. The agreement is subject to the approval of the state regulators.

REVENUES

We generate revenues primarily from premiums we receive from the states in which we operate to provide health benefits to our members. We receive a fixed premium per member per month pursuant to our state contracts. We generally receive premiums in advance of providing services and recognize premium revenue during the period in which we are obligated to provide services to our members. We also generate administrative services fees for providing services to SSI members on a non-risk basis.

The primary driver of our increasing revenues has been membership growth. We have increased our membership through internal growth and acquisitions. From June 30, 2001 to June 30, 2002, our membership grew 30.7% as a result of additions to our provider networks and growth in the number of Medicaid beneficiaries. The following table sets forth our membership by state:

	JUNE 30,	
	2002	2001
Wisconsin	123,900	103,000
Indiana	92,800	54,600
Texas	61,900	55,600
Total	278,600	213,200

The following table depicts membership by line of business:

	JUNE 30,	
	2002	2001
Medicaid	254,700	194,800
CHIP	23,900	18,400
Total	278,600	213,200

OPERATING EXPENSES

Our operating expenses include medical services costs and general and administrative expenses.

Our medical services costs include payments to physicians, hospitals, and other providers for healthcare and specialty product claims. Medical service costs also include estimates of medical expenses incurred but not yet reported, or IBNR. Monthly, we estimate our IBNR based on a number of factors, including inpatient hospital utilization data and prior claims experience. As part of this review, we also

consider the costs to process medical claims, and estimates of amounts to cover uncertainties related to fluctuations in physician billing patterns, membership, products and inpatient hospital trends. These estimates are adjusted as more information becomes available. We utilize the services of independent actuarial consultants who are contracted to review our estimates quarterly. While we believe that our process for estimating IBNR is actuarially sound, we cannot assure you that healthcare claim costs will not exceed our estimates.

Our results of operations depend on our ability to manage expenses related to health benefits and to accurately predict costs incurred. The table below depicts our health benefits ratio, which represents medical services costs as a percentage of premium revenues and reflects the direct relationship between the premium received and the medical services provided. Our stabilization of the ratio primarily reflects improved provider contract terms and premium rate increases in our markets served.

<TABLE>
<CAPTION>

	THREE MONTHS ENDED JUNE 30,		SIX MONTHS ENDED JUNE 30,	
	2002	2001	2002	2001
<S>	<C>	<C>	<C>	<C>
Health benefits ratio	82.0%	82.6%	82.2%	83.0%

</TABLE>

Our general and administrative expenses primarily reflect wages and benefits and other administrative costs related to our employee base, including those fees incurred to provide services to our members. Some of these services are provided locally, while others are delivered to our health plans from a centralized location. This approach provides the opportunity to control both direct and indirect costs. The major centralized functions are claims processing, information systems, finance, medical management support and administration. The following table sets forth the general and administrative expense ratio, which represents general and administrative expenses as a percent of total revenues and reflects the relationship between revenues earned and the costs necessary to drive those revenues. The improvement in the ratio reflects growth in membership and revenues combined with leveraging our overall infrastructure.

<TABLE>
<CAPTION>

	THREE MONTHS ENDED JUNE 30,		SIX MONTHS ENDED JUNE 30,	
	2002	2001	2002	2001
<S>	<C>	<C>	<C>	<C>
General and administrative expenses ratio	10.9%	11.9%	11.0%	12.2%

</TABLE>

OTHER INCOME

Other income consists principally of investment and other income and interest expense.

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

- Interest expense primarily reflected interest paid on our subordinated notes, which we repaid in full in December 2001.

RESULTS OF OPERATIONS

SIX MONTHS ENDED JUNE 30, 2002 COMPARED TO SIX MONTHS ENDED JUNE 30, 2001

Revenues

Premiums for the six months ended June 30, 2002 increased $52.5 million, or 34.8%, to $203.2 million from $150.7 million in 2001. This increase was due to increases in membership in each of our markets and an increase in premium rates.

Administrative services fees for the six months ended June 30, 2002 increased $29,000 or 15.9% to $211,00 from $182,000 in 2001 as a result of increases in our SSI membership.

Operating Expenses

Medical services costs for the six months ended June 30, 2002 increased $42.0 million or 33.6%, to $167.0 million from $125.0 million in 2001. This increase primarily reflected the growth in our membership.

General and administrative expenses for the six months ended June 30, 2002 increased $3.9 million, or 21.3%, to $22.3 million from $18.4 million in 2001. This increase reflected a higher level of wages and related expenses for additional staff to support our membership growth.

Other Income

Other income for the six months ended June 30, 2002 increased $179,000, or 10.5%, to $1.9 million from $1.7 million in 2001. This primarily reflected a decrease in interest expense resulting from our repayment of subordinated notes in December 2001. In addition, our annualized rate of return on investments for the six months ended June 30, 2002 was 3.1%, as compared with 3.4% for the six months ended June 30, 2001.

Income Tax Expense

For the six months ended June 30, 2002, we recorded income tax expense of $6.3 million based on a 39.9% effective tax rate. For the six months ended June 30, 2001, we recorded income tax expense of $3.7 million based on an effective tax rate of 40.7%.

THREE MONTHS ENDED JUNE 30, 2002 COMPARED TO THREE MONTHS ENDED JUNE 30, 2001

Revenues

Premiums for the three months ended June 30, 2002 increased $27.0 million, or 33.6%, to $107.5 million from $80.5 million in 2001. This increase was due to increases in membership in each of our markets and an increase in premium rates.

Administrative services fees for the three months ended June 30, 2002 increased $5,000 or 4.9% to $107,000 from $102,000 in 2001 as a result of increases in our SSI membership.

Operating Expenses

Medical services costs for the three months ended June 30, 2002 increased $21.6 million or 32.6%, to $88.1 million from $66.5 million in 2001. This increase primarily reflected the growth in our membership.

General and administrative expenses for the three months ended June 30, 2002 increased $2.2 million, or 23.0%, to $11.8 million from $9.6 million in 2001. This increase reflected a higher level of wages and related expenses for additional staff to support our membership growth.

Other Income

Other income for the three months ended June 30, 2002 increased $135,000, or 16.3%, to $965,000 from $830,000 in 2001. This primarily reflected a decrease in interest expense resulting from our repayment of subordinated notes in December 2001.

Income Tax Expense

For the three months ended June 30, 2002, we recorded income tax expense of $3.4 million based on a 39.7% effective tax rate. For the three months ended June 30, 2001, we recorded income tax expense of $2.1 million based on an effective tax rate of 39.5%.

LIQUIDITY AND CAPITAL RESOURCES

On May 22, 2002, we closed our follow-on public offering of 5,000,000 shares of common stock at $24.75 per share. Of the 5,000,000 shares, 4,600,000 shares were offered by selling stockholders and 400,000 by us. On June 5, 2002, the underwriters of our follow-on public offering exercised their over-allotment option to purchase 679,505 additional shares from selling stockholders and 70,495 additional shares from us. We received net proceeds totaling $10.3 million from the two closings for the follow-on offering.

Our operating activities provided cash of $8.9 million for the six months ended June 30, 2002 compared to $28.0 million for the six months ended June 30, 2001. The decrease in cash provided in the six months ended June 30, 2002 compared to the six months ended June 30, 2001 was due to the timing of capitation payments and vendor payments.

Our investing activities used cash of $63.9 million for 2002 and $555,000 in 2001. Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets. As such, as of June 30,

2002, our investment portfolio consisted primarily of municipal bonds with an average duration of three months. Cash is invested in investment vehicles such as municipal bonds, commercial paper, U.S. government-backed agencies and U.S. Treasury instruments. The average portfolio return was 5.6% for the year ended December 31, 2001 and 3.1% for the six months ended June 30, 2002.

Our financing activities provided cash of $10.4 million for the six months ended June 30, 2002 and $17,000 for the six months ended June 30, 2001. During the six months ended June 30, 2002, financing cash flows primarily consisted of the net proceeds from the issuance of common stock through the follow-on public offering.

In 2002, we anticipate purchasing $3.6 million of new software, software and hardware upgrades, and furniture, equipment and leasehold improvements related to office and market expansions. We have purchased $2.4 million in capital assets during the six months ended June 30, 2002.

Our principal contractual obligations at June 30, 2002 consisted of obligations under operating leases. The significant annual noncancelable lease payments are as follows (in thousands):

	Payments Due
July 1, 2002 through December 31, 2002.....	$ 1,121
2003.....	2,149
2004.....	2,112
2005.....	2,070
2006.....	1,788
Thereafter.....	5,836
	$ 15,076

No significant new obligations were incurred during the six months ended June 30, 2002.

At June 30, 2002, we had working capital of $(3.1) million as compared to $34.8 million at December 31, 2001. Our working capital is often negative due to our efforts to increase investment returns through purchases of long-term investments, which have maturities of greater than one year. Our investment policies are also designed to provide liquidity and preserve capital. We manage our short-term and long-term investments to ensure that a sufficient portion is held in investments that are highly liquid and can be sold to fund working capital as needed.

Cash, cash equivalents and short-term investments were $50.5 million at June 30, 2002 and $90.0 million at December 31, 2001. Long-term investments were $78.8 million at June 30, 2002 and $22.3 million at December 31, 2001. Based on our operating plan, we expect that our available cash, cash equivalents and investments, and cash from our operations will be sufficient to finance our operations and capital expenditures for at least 12 months from the date of this report.

On May 1, 2002, we obtained a $25 million revolving line of credit facility from a financial institution. The line of credit has a term of one year and interest rates based on prime, floating and LIBOR rates. We have granted to the financial institution a security interest in the common stock of our subsidiaries. The facility includes financial covenants requiring a minimum quarterly EBITDA of $1.5 million and minimum tangible net worth of $52.2 million. As of June 30, 2002, all covenants have been met. We are required to obtain the lender's consent if any proposed acquisition would result in violation of one of the covenants contained in the line of credit. As of July 24, 2002, we have borrowed no funds under the line of credit facility.

In addition, we have raised capital from time to time to fund planned geographic and product expansion, necessary regulatory reserves, and acquisitions of healthcare contracts. We may use our existing funds, including proceeds from our two public offerings, to acquire Medicaid and CHIP contract rights and related assets to increase our membership and to expand our business into new service areas. We are currently party to a definitive agreement that would expand our CHIP program in Texas. This proposed acquisition is subject to regulatory approval and other conditions, and there can be no assurance that we will complete the acquisition or any future proposed acquisition.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

Our operations are conducted through our subsidiaries. As managed care organizations, our subsidiaries are subject to state regulations that, among other things, may require the maintenance of minimum levels of statutory

capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us.

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 June 30, 2002, our subsidiaries had aggregate statutory capital and surplus of $19.9 million, compared with the required minimum aggregate statutory capital and surplus requirements of $10.8 million.

In 1998, the National Association of Insurance Commissioners adopted guidelines, which, to the extent that they have been implemented by the states, set new minimum capitalization requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. Risk-based capital rules for managed care organizations, which may vary from state to state, are currently being considered for adoption. Wisconsin and Texas adopted various forms of the rules as of December 31, 1999. The managed care organization rules, if adopted by Indiana in their proposed form, may increase the minimum capital required for our subsidiary.

RECENT ACCOUNTING PRONOUNCEMENTS

In July 2001, SFAS No. 142, "Goodwill and Other Intangible Assets," was issued which requires that goodwill and intangible assets with indefinite useful lives no longer be amortized, but instead tested at least annually for impairment. We have adopted SFAS No. 142 effective January 1, 2002. Goodwill amortization has been discontinued. For the three months ended June 30, 2001, this adjustment would have added $122,000 in net earnings, or $0.02 per diluted share and $0.13 per basic share. For the six months ended June 30, 2001, this adjustment would have added $245,000 in net earnings, or $0.03 per diluted share and $0.27 per basic share. We review goodwill and other long-lived assets annually for impairment. We recognize impairment losses if expected undiscounted future cash flows of the related assets are less than their carrying value. An impairment loss represents the amount by which the carrying value of an asset exceeds the fair value of the asset. We did not recognize any impairment losses for the periods presented.

In August 2001, the FASB issued SFAS No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets." SFAS No. 144 provides updated guidance concerning the recognition and measurement of an impairment loss for certain types of long-lived assets. It also expands the scope of a discontinued operation to include a component of an entity. SFAS No. 144 is effective for financial statements issued for fiscal years beginning after December 15, 2001, and interim periods within those years. The adoption of the provisions of SFAS No. 144 did not have a material impact on our results of operations, financial position or cash flows.

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 prospectus, including our consolidated financial statements and related notes. The risks and uncertainties described below are those that we currently believe may materially affect our company. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial also may become important factors that affect our company.

RISKS RELATED TO BEING A REGULATED ENTITY

Reductions in Medicaid Funding Could Substantially Reduce Our Profitability.

Nearly all of our revenues come from Medicaid premiums. The base premium rate paid by each state differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix and member eligibility categories. Future levels of Medicaid premium rates may be affected by continued government efforts to contain medical costs and may further be affected by state and federal budgetary constraints. Changes to Medicaid programs could reduce the number of persons enrolled or eligible, reduce the amount of reimbursement or payment levels, or increase our administrative or healthcare costs under those programs. States periodically consider reducing or reallocating the amount of money they spend for Medicaid. We believe that additional reductions in Medicaid payments could substantially reduce our profitability. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds.

If Our Medicaid and CHIP Contracts are Terminated or are not Renewed, Our Business will Suffer.

We provide managed care programs and selected services to individuals receiving benefits under Medicaid, including SSI and CHIP. We provide those

healthcare services under five contracts with regulatory entities in the areas in which we operate. The contracts expire on various dates between December 31, 2002 and December 31, 2003. Our contracts with the states of Indiana and Wisconsin accounted for 73% of our revenues for the year ended December 31, 2001. Our contracts may be terminated if we fail to perform up to the standards set by state regulatory agencies. In addition, the Indiana contract under which we operate can be terminated by the state without cause. Our contracts are generally intended to run for two years and may be extended for one or two additional years if the state or its contractor elects to do so. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. If any of our contracts are terminated, not renewed, or renewed on less favorable terms, our business will suffer, and our operating results may be materially affected.

Changes in Government Regulations Designed to Protect Providers and Members Rather than Our Stockholders Could Force Us to Change How We Operate and Could Harm Our Business.

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

- force us to restructure our relationships with providers within our network;

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

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

Regulations may Decrease the Profitability of Our Health Plans.

Our Texas plans are required to pay a rebate to the state in the event profits exceed established levels. This regulatory requirement, changes in this requirement or the adoption of similar requirements by our other regulators may limit our ability to increase our overall profits as a percentage of revenues. The State of Texas has implemented and is enforcing a penalty provision for failure to pay claims in a timely manner. Failure to meet this requirement can result in financial fines and penalties. In addition, states may attempt to reduce their contract premium rates if regulators perceive our medical loss ratio as too low. Any of these regulatory actions could harm our operating results.

Also, on January 18, 2002, the federal Centers for Medicare and Medicaid Services, or CMS, published a final rule that removed an exception contained in the federal Medicaid reimbursement regulations permitting states to reimburse non-state government-owned or operated hospitals for inpatient and outpatient hospital services at amounts up to 150 percent of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles. This development in federal law could decrease the profitability of our health plans.

Failure to Comply with Government Regulations Could Subject Us to Civil and Criminal Penalties.

Federal and state governments have enacted fraud and abuse laws and other laws to protect patients' privacy and access to healthcare. Violation of these and other laws or regulations governing our operations or the operations of our providers could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide services, the suspension or revocation of our licenses or our exclusion from participating in the Medicaid, SSI and CHIP programs. Because of these potential sanctions, we seek to monitor our

compliance and that of our providers with federal and state fraud and abuse and other healthcare laws on an ongoing basis. These penalties or exclusions, were they to occur as the result of our actions or omissions, or our inability to monitor the compliance of our providers, would negatively impact our ability to operate our business. For example, failure to pay our providers promptly could result in the imposition of fines and other penalties. In some states, we may be subject to regulation by more than one governmental authority, which may impose overlapping or inconsistent regulations.

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA created civil penalties for, among other things, billing for medically unnecessary goods or services. HIPAA established new enforcement mechanisms to combat fraud and abuse, including a whistle blower program. Further, HIPAA imposes

civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of individually-identifiable health information. Congress may enact additional legislation to increase penalties and to create a private right of action under HIPAA, which would entitle patients to seek monetary damages for violations of the privacy rules.

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

In August 2000, the Department of Health and Human Services, or HHS, issued a new regulation under HIPAA requiring the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. We are required to comply with the new regulation by October 2002, or submit a "compliance plan" with HHS on or before October 15, 2002, that details how we will meet the extended compliance deadline of October 16, 2003. In addition, Texas has indicated that it may impose an earlier compliance deadline. In August 1998, HHS proposed a regulation that would require healthcare participants to implement organizational and technical practices to protect the security of electronically maintained or transmitted health-related information. In December 2000, HHS issued a new regulation mandating heightened privacy and confidentiality protections under HIPAA that became effective on April 14, 2001. Compliance with this regulation will be required by April 14, 2003.

In January 2001, CMS (then the Health Care Financing Administration) published new regulations regarding Medicaid managed care. CMS subsequently delayed the effective date of these regulations until August 16, 2002. In August 2001, CMS proposed new regulations that would modify the January regulations. If adopted, these regulations would implement the requirements of the Balanced Budget Act of 1997 that are intended to give states more flexibility in their administration of Medicaid managed care programs, provide new patient protections for Medicaid managed care enrollees and require states to meet new actuarial soundness requirements.

The Bush Administration's issuance of new regulations, its review of the existing HIPAA rules and other newly published regulations, the states' ability to promulgate stricter rules, and uncertainty regarding many aspects of the regulations may make compliance with the relatively new regulatory landscape difficult. Our existing programs and systems would not enable us to comply in all respects with these new regulations. In order to comply with the regulatory requirements, we will be required to employ additional or different programs and systems, the costs of which are unknown to us at this time. Further, compliance with these regulations would require changes to many of the procedures we currently use to conduct our business, which may lead to additional costs that we have not yet identified. We do not know whether, or the extent to which, we will be able to recover our costs of complying with these new regulations from the states. The new regulations and the related compliance costs could have a material adverse effect on our business.

Changes in Healthcare Law may Reduce Our Profitability.

Numerous proposals relating to changes in healthcare law have been introduced, some of which have been passed by Congress and the states in which we operate or may operate in the future. Changes in applicable laws and regulations are continually being considered, and interpretations of existing laws and rules may also change from time to time. We are unable to predict what regulatory changes may occur or what effect any particular change may have on our business. These changes could reduce the number of persons enrolled or eligible for Medicaid and reduce the reimbursement or payment levels for medical services. More generally, we are unable to predict whether new laws or proposals will favor or hinder the growth of managed healthcare.

We cannot predict the outcome of these legislative or regulatory proposals or the effect that they will have on us. Legislation or regulations that require us to change our current manner of operation, provide

additional benefits or change our contract arrangements may seriously harm our operations and financial results.

If We are Unable to Participate in CHIP Programs Our Growth Rate may be Limited.

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

If State Regulators do not Approve Payments of Dividends and Distributions by Our Subsidiaries to Us, We may not Have Sufficient Funds to Implement Our Business Strategy.

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

RISKS RELATED TO OUR BUSINESS

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

Nearly all of our revenues are generated by premiums consisting of fixed monthly payments per member. These premiums are fixed by contract, and we are obligated during the contract periods to provide healthcare services as established by the state governments. We use a large portion of our revenues to pay the costs of healthcare services delivered to our customers. If premiums do not increase when expenses related to medical services rise, our earnings would be affected negatively. In addition, our actual medical services costs may exceed our estimates, which would cause our health benefits ratio, or our expenses related to medical services as a percentage of premium revenues, to increase and our profits to decline. In addition, it is possible for a state to increase the rates payable to the hospitals without granting a corresponding increase in premiums to us. If this were to occur in one or more of the states in which we operate, our profitability would be harmed.

Failure to Effectively Manage Our Medical Costs or Related Administrative Costs Would Reduce Our Profitability.

Our profitability depends, to a significant degree, on our ability to predict and effectively manage expenses related to health benefits. We have less control over the costs related to medical services than we do over our general and administrative expenses. Historically, our health benefits ratio has fluctuated. For example, our health benefits ratio was 82.2% for the six months ended June 30, 2002, 83.0% for 2001 and 84.3% for 2000, but was 88.9% for 1999 and 88.4% for 1998. Because of the narrow margins of our health plan business, relatively small changes in our health benefits ratio can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of use of healthcare services, hospital costs, pharmaceutical costs, major epidemics, new medical technologies and other external factors, including general economic conditions such as inflation levels, are beyond our control and could reduce our ability to predict and effectively control the costs of providing health benefits. We may not be able to manage costs effectively in the future. If our costs related to health benefits increase, our profits could be reduced or we may not remain profitable.

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

Our medical expenses include estimates of 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. 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 accurately estimate IBNR may also affect our ability to take timely corrective actions, further harming our results.

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

Historically, the acquisition of Medicaid contract rights and related assets of other health plans, both in our existing service areas and in new markets, has accounted for a significant amount of our growth. For example, our acquisition of contract rights from Humana in February 2001 accounted for 88.0% of the increase in our net premium revenues for 2001 compared to 2000. Many of the other potential purchasers of Medicaid assets have greater financial resources than we have. In addition, many of the sellers are interested either in (1) selling, along with their Medicaid assets, other assets in which we do not have an interest or (2) selling their companies, including their liabilities, as opposed to the assets of their ongoing businesses.

We generally are required to obtain regulatory approval from one or more state agencies when making acquisitions. In the case of an acquisition of a business located in a state in which we do not currently operate, we would be required to obtain the necessary licenses to operate in that state. In addition, even if we already operate in a state in which we acquire a new business, we would be required to obtain additional regulatory approval if the acquisition would result in our operating in an area of the state in which we did not operate previously and we could be required to renegotiate provider contracts of the acquired business. We cannot assure you that we would be able to comply with these regulatory requirements for an acquisition in a timely manner, or at all. In deciding whether to approve a proposed acquisition, state regulators may consider a number of factors outside our control, including giving preference to competing offers made by locally owned entities or by not-for-profit entities. Furthermore, we are party to a revolving line of credit facility that prohibits some acquisitions without the consent of our bank lender.

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

- additional personnel who are not familiar with our operations and corporate culture;

- existing provider networks, which may operate on different terms than our existing networks;

- existing members, who may decide to switch to another healthcare plan; and

- disparate administrative, accounting and finance, and information systems.

For example, in the Humana acquisition, the configuration of new provider contracts temporarily extended our claims payment process.

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

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

Failure to Achieve Timely Profitability in Any Business Would Negatively Affect Our Results of Operations.

Start-up costs associated with a new business can be substantial. For example, in order to obtain a certificate of authority in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to obtain a state contract and process claims. If we were unsuccessful in obtaining the necessary license, winning the bid to provide service or attracting members in numbers sufficient to cover our costs, any new business of ours would fail. We also could be obligated by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or recover start-up costs. In addition, we may not be able to effectively commercialize any new programs or services we seek to market to third parties. The expenses associated with starting up a new business could have a significant impact on our results of operations if we are unable to achieve profitable operations in a timely fashion.

We Derive All of Our Revenues from Operations in Three States, and Our Operating Results Would be Materially Affected by a Decrease in Revenues or Profitability in Any One of Those States.

Operations in Wisconsin, Indiana and Texas account for all of our revenues. If we were unable to continue to operate in each of those states or if our

current operations in any portion of one of those states were significantly curtailed, our revenues would decrease materially. In the first half of 2001, our membership in Indiana declined by approximately 46,000 due to a subcontracting provider organization terminating a percent-of-premium arrangement. In 2000, we reduced our service area in Wisconsin from 36 to 18 counties. In 1999 and 2000, we terminated our services to most of the southern counties of Indiana. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly, depending on legislative actions, economic conditions and similar factors in those states. Our inability to continue to operate in any of the states in which we operate would harm our business.

Competition may Limit Our Ability to Increase Penetration of the Markets that We Serve.

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

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

In addition, in order to increase our membership in the markets we currently serve, we believe that we must continue to develop and implement community-specific products, alliances with key providers and localized outreach and educational programs. If we are unable to develop and implement these initiatives,

or if our competitors are more successful than we are in doing so, we may not be able to further penetrate our existing markets.

If We are Unable to Maintain Satisfactory Relationships with Our Provider Networks, Our Profitability will be Harmed.

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

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

We will be required to establish acceptable provider networks prior to entering new markets. We may be unable to enter into agreements with providers in new markets on a timely basis or under favorable terms.

If we are unable to retain our current provider contracts or enter into new provider contracts timely or on favorable terms, our profitability will be harmed.

We may be Unable to Attract and Retain Key Personnel.

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our Medicaid managed care business. If we lose one or more members of our senior management team, including our chief executive officer, Michael F. Neidorff, who has been instrumental in developing our mission and forging our business relationships, our business and operating results could be harmed. We do not have an employment agreement with Mr. Neidorff, and we cannot assure you that we will be able to retain his services. Our ability to replace any departed members of our senior management or other

key employees may be difficult and may take an extended period of time because of the limited number of individuals in the Medicaid managed care industry with the breadth of skills and experience required to operate and expand successfully a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel.

Negative Publicity Regarding the Managed Care Industry may Harm Our Business and Operating Results.

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

Claims Relating to Medical Malpractice Could Cause Us to Incur Significant Expenses.

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

Growth in the Number of Medicaid-Eligible Persons During Economic Downturns Could Cause Our Operating Results and Stock Prices to Suffer if State and Federal Budgets Decrease or do not Increase.

Less favorable economic conditions may cause our membership to increase as more people become eligible to receive Medicaid benefits. During such economic downturns, however, state and federal budgets could decrease, causing states to attempt to cut healthcare programs, benefits and rates. In particular, the terrorist acts of September 11, 2001 created an uncertain economic environment that has continued to date, and we cannot predict the impact of these events, other acts of terrorism or related military action on federal or state funding of healthcare programs or on the size of the Medicaid-eligible population. If federal funding were decreased or unchanged while our membership was increasing, our results of operations would suffer.

Growth in the Number of Medicaid-Eligible Persons may be Countercyclical, Which Could Cause Our Operating Results to Suffer When General Economic Conditions are Improving.

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

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

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

If We are Unable to Integrate and Manage Our Information Systems Effectively, Our Operations Could be Disrupted.

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

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

We may not be Able to Obtain and Maintain Adequate Insurance.

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

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

As of June 30, 2002, we had short-term investments of $6.1 million and long-term investments of $78.8 million. The short-term investments primarily consist of securities with original maturities between three and twelve months. The long-term investments consist of municipal bonds and have original maturities greater than one year. The majority of our investments are highly liquid, with a weighted average duration of three months at June 30, 2002. Our investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold the short-term investments to maturity, and as a result, we would not expect the value of these investments to decline significantly as a result of a sudden change in market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at June 30, 2002, the fair value of our long-term income investments would decrease by approximately $834,000. Similarly, a 1% decrease in market interest rates at June 30, 2002 would result in an increase of the fair value of our investments of approximately $834,000. Declines in interest rates over time will reduce our investment income.

PART II. OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

From 1998 to 2000, we provided Medicaid services in certain regions of Indiana as subcontractor with Maxicare, Indiana, Inc. In June 2001, the Insurance Commissioner of the Indiana Department of Insurance declared Maxicare insolvent and ordered Maxicare into liquidation. In September 2001, we filed an adversary proceeding in Marion County Circuit Court against Maxicare and the Indiana Insurance Commissioner seeking declaratory and injunctive relief and the turnover of funds. This proceeding is based on our belief that the State of Indiana's proposed liquidation plan for Maxicare does not adequately address our claims for approximately $4.7 million that we believe is owed to us by Maxicare. Maxicare and the Indiana Insurance Commissioner subsequently filed a counterclaim suit against us seeking, among other things, to avoid any claims we have for funds held by Maxicare and to recover payments previously made to us by Maxicare in the amount of approximately $2.0 million, on the grounds those payments constituted preferential transfers. A bench trial is scheduled for July 26, 2002.

ITEM 2. CHANGES IN SECURITIES AND USE OF PROCEEDS

None.

ITEM 3. DEFAULTS UPON SENIOR SECURITIES

None.

ITEM 4. SUBMISSION OF MATTERS TO A VOTE OF SECURITY HOLDERS

We held our annual meeting of stockholders on June 3, 2002. At the meeting, Samuel E. Bradt and Michael F. Neidorff were reelected as Class I directors. The vote with respect to each nominee is set forth below:

<TABLE>
<CAPTION>

	Total Vote for Each Director	Total Vote Withheld From Each Director
<S>	<C>	<C>
Mr. Bradt	7,743,809	92,297
Mr. Neidorff	7,579,134	256,972

</TABLE>

Additional directors of the company whose terms of office continued after the meeting are Edward L. Cahill, Howard E. Cox, Jr., Robert K. Ditmore, Claire W. Johnson and Richard P. Wiederhold.

Our stockholders approved our 2002 Employee Stock Purchase Plan authorizing the issuance of up to 300,000 shares of common stock for purchase by eligible employees at a discounted price. The plan was approved by a vote of 7,821,856 shares for, 14,250 shares against and -0- shares abstaining.

ITEM 5. OTHER INFORMATION

None.

ITEM 6. EXHIBITS AND REPORT ON FORM 8-K

(a) Exhibits

The following exhibits are incorporated by reference from our Amendment No. 2 to Form S-1 filed with the SEC on May 14, 2002

10.1 Loan Agreement between Centene Corporation and LaSalle Bank National Association, dated May 1, 2002

10.1a Revolving Note between Centene Corporation and LaSalle Bank National Association, dated May 1, 2002

10.1b Stock Pledge Agreement between Centene Corporation and LaSalle Bank National Association, dated May 1, 2002

(b) Report on Form 8-K

On June 20, 2002 we filed a current report on Form 8-K with respect to our engagement of PricewaterhouseCoopers LLP as our independent accountants succeeding Arthur Andersen LLP.

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.

Date: July 24, 2002

CENTENE CORPORATION

By: /s/ Michael F. Neidorff

MICHAEL F. NEIDORFF
President and Chief Executive Officer

By: /s/ Karey L. Witty

KAREY L. WITTY
Senior Vice President, Chief Financial Officer, Secretary and Treasurer