UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

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

For the quarterly period ended March 31, 2007

OR

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

For the transition period from to

Commission file number 000-33395

CENTENE CORPORATION

(Exact name of registrant as specified in its charter)

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

Registrant's telephone number, including area code:

(314) 725-4477

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated 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 [X] 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 [X]

As of April 16, 2007, the registrant had 43,613,802 shares of common stock outstanding.

CENTENE CORPORATION

QUARTERLY REPORT ON FORM 10-Q

TABLE OF CONTENTS

PART I

FINANCIAL INFORMATION

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

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS
(In thousands, except share data)

	March 31, 2007	December 31, 2006
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 311,905	$ 271,047
Premium and related receivables	78,076	91,664
Short-term investments, at fair value (amortized cost $43,309 and $67,199, respectively)	43,054	66,921
Other current assets	48,499	22,189
Total current assets	481,534	451,821
Long-term investments, at fair value (amortized cost $183,388 and $146,980, respectively)	182,267	145,417
Restricted deposits, at fair value (amortized cost $25,662 and $25,422, respectively)	25,562	25,265
Property, software and equipment, net	121,403	110,688
Goodwill	130,484	135,877
Other intangible assets, net	16,011	16,202
Other assets	14,116	9,710
Total assets	$ 971,377	$ 894,980
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liabilities	$ 275,965	$ 280,441
Accounts payable and accrued expenses	75,842	72,723
Unearned revenue	38,613	33,816
Current portion of long-term debt	965	971
Total current liabilities	391,385	387,951
Long-term debt	200,404	174,646
Other liabilities	10,124	5,960
Total liabilities	601,913	568,557
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; issued and outstanding 43,448,324 and 43,369,918 shares, respectively	44	44
Additional paid-in capital	213,797	209,340
Accumulated other comprehensive income:		
Unrealized loss on investments, net of tax	(925)	(1,251)
Retained earnings	156,548	118,290
Total stockholders' equity	369,464	326,423
Total liabilities and stockholders' equity	$ 971,377	$ 894,980

See notes to consolidated financial statements.

CENTENE CORPORATION AND SUBSIDIARIES

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

	Three Months Ended March 31,	
	2007	**2006**
	(Unaudited)	
Revenues:		
Premium	$ 649,243	$ 435,562
Service	21,592	19,516
Total revenues	670,835	455,078
Expenses:		
Medical costs	535,406	361,672
Cost of services	15,630	15,588
General and administrative expenses	106,866	65,222
Gain on sale of FirstGuard Missouri	(4,218)	—
Total operating expenses	653,684	442,482
Earnings from operations	17,151	12,596
Other income (expense):		
Investment and other income	4,501	3,540
Interest expense	(3,132)	(1,998)
Earnings before income taxes	18,520	14,138
Income tax (benefit) expense	(19,691)	5,372
Net earnings	$ 38,211	$ 8,766
Earnings per share:		
Basic earnings per common share	$ 0.88	$ 0.20
Diluted earnings per common share	$ 0.85	$ 0.20
Weighted average number of shares outstanding:		
Basic	43,433,319	42,987,892
Diluted	44,923,340	44,750,271

See notes to consolidated financial statements.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)

	Three Months Ended March 31,	
	2007	2006
	(Unaudited)	
Cash flows from operating activities:		
Net earnings	$ 38,211	$ 8,766
Adjustments to reconcile net earnings to net cash provided by operating activities —		
Depreciation and amortization	6,274	4,520
Stock compensation expense	3,871	3,417
Deferred income taxes	(1,398)	232
Gain on sale of FirstGuard Missouri	(4,218)	—
Changes in assets and liabilities —		
Premium and related receivables	13,588	(15,812)
Other current assets	(26,336)	(2,894)
Other assets	(636)	(158)
Medical claims liabilities	(4,340)	2,278
Unearned revenue	4,796	(934)
Accounts payable and accrued expenses	1,309	9,937
Other operating activities	4,859	(9)
Net cash provided by operating activities	35,980	9,343
Cash flows from investing activities:		
Purchases of property, software and equipment	(14,794)	(14,136)
Purchases of investments	(135,866)	(53,194)
Sales and maturities of investments	122,835	33,827
Proceeds from asset sales	10,848	—
Acquisitions, net of cash acquired	(400)	(39,912)
Net cash used in investing activities	(17,377)	(73,415)
Cash flows from financing activities:		
Proceeds from exercise of stock options	868	2,139
Proceeds from borrowings	191,000	37,000
Payment of long-term debt	(165,248)	(2,285)
Excess tax benefits from stock compensation	417	1,454
Common stock repurchases	(644)	(3,082)
Debt issue costs	(4,138)	—
Net cash provided by financing activities	22,255	35,226
Net increase (decrease) in cash and cash equivalents	40,858	(28,846)
Cash and cash equivalents, beginning of period	271,047	147,358
Cash and cash equivalents, end of period	$ 311,905	$ 118,512
Interest paid	$ 2,999	$ 2,037
Income taxes paid	$ 5,801	$ 911

See notes to consolidated financial statements.

CENTENE CORPORATION AND SUBSIDIARIES

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

1. Organization and Operations

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

2. Basis of Presentation

The unaudited interim financial statements herein have been prepared by the Company pursuant to the rules and regulations of the Securities and Exchange Commission. The accompanying interim financial statements have been prepared under the presumption that users of the interim financial information have either read or have access to the audited financial statements for the fiscal year ended December 31, 2006. Accordingly, footnote disclosures, which would substantially duplicate the disclosures contained in the December 31, 2006 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 2006 amounts in the consolidated financial statements have been reclassified to conform to the 2007 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

3. Recent Accounting Pronouncements

In June 2006, the FASB ratified the consensus reached on Emerging Issues Task Force, or EITF, Issue No. 06-3, "How Sales Taxes Collected from Customers and Remitted to Governmental Authorities Should Be Presented in the Income Statement (That is, Gross Versus Net Presentation)", or EITF 06-3. The EITF reached a consensus that the presentation of taxes on either a gross or net basis is an accounting policy decision. The Company is evaluating the provisions of EITF 06-3 as it applies to premium taxes. Premium taxes are assessed by certain states as percentage of premiums paid to the Company by those states. Premium taxes of $18,216 and $4,305 for the three months ended March 31, 2007 and 2006, respectively, were reported as a component of revenues and general and administrative expenses.

The Company adopted the provisions of FASB Interpretation No. 48, "Accounting for Uncertainty in Income Taxes", or FIN 48, on January 1, 2007. FIN 48 clarifies whether or not to recognize assets or liabilities for tax positions taken that may be challenged by a taxing authority. As a result of the implementation of FIN 48, the Company recognized a $47 decrease in the liability for unrecognized tax benefits, which was accounted for as an increase to retained earnings. As of January 1, 2007, the Company has $3,114 of gross unrecognized tax benefits. Of this total, $888 (net of the federal benefit on state issues) would decrease income tax expense if recognized and the remainder would reduce goodwill if recognized.

The Company recognizes interest accrued related to unrecognized tax benefits in the provision for income taxes. As of January 1, 2007, interest accrued was approximately $293, net of federal tax benefit. No penalties have been accrued. An additional $34 of interest was accrued in first quarter 2007.

During first quarter 2007, the Company's liability for unrecognized tax benefits increased by $1,563, of which the entire amount would reduce income tax expense if recognized. The increase is related to an Internal Revenue Code Section 165 loss on the Company's investment in FirstGuard Kansas' stock to be recognized in the Company's 2007 federal and state returns.

The Company's federal income tax returns for 2003 through 2006 are open tax years. The Company files in numerous state jurisdictions with varying statutes of limitation. The Company's unrecognized state tax benefits are related to state returns open from 2002 through 2006 or 2003 through 2006 depending on each state's statute of limitation.

4. FirstGuard Health Plans

In 2006, FirstGuard Health Plan Kansas, Inc., or FirstGuard Kansas, a wholly owned subsidiary, received notification that its Medicaid contract scheduled to terminate December 31, 2006 would not be renewed. In 2006, the Company also evaluated its strategic alternatives for its Missouri subsidiary, FirstGuard Health Plan, Inc., or FirstGuard Missouri, and decided to divest the business. The sale of the operating assets of FirstGuard Missouri was completed effective February 1, 2007.

Under the terms of the asset sale agreement, the Company received an initial payment upon the sale of FirstGuard Missouri resulting in a gain of $4,218 in 2007. The Company may recognize additional gain in 2007 because it is entitled to a second payment currently estimated at approximately $3,000, contingent upon the membership levels of the purchaser as of June 1, 2007. Goodwill associated with FirstGuard written off as part of the transaction was $5,995.

In March 2007, the Company abandoned the stock of FirstGuard Kansas to an unrelated entity. As a result of that abandonment, the Company recognized expense of $1,602 for the write-off of the remaining assets in that entity and a $29,919 tax benefit for the tax deduction the Company will receive for the basis of that stock. The asset write-off is recorded in investment and other income. The income tax receivable associated with the tax deduction is recorded as a component of other current assets.

The Company has incurred $7,801 of FirstGuard exit costs consisting primarily of lease termination fees and employee severance costs. $6,202 was incurred in 2006, of which $3,027 was accrued at December 31, 2006. During the three months ended March 31, 2007, the Company incurred an additional $1,599 of exit costs and made payments of $3,007. At March 31, 2007, the remaining accrual for these costs was $1,619.

5. Debt

In March 2007, the Company issued $175,000 aggregate principal amount of 7 ¼% Senior Notes due April 1, 2014, or the Notes. The Notes have not been registered under the Securities Act of 1933, as amended, however, the Company intends to register the Notes pursuant to a registration rights agreement with the initial purchasers. The agreement contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio. Interest will be paid semi-annually beginning in October 2007.

At March 31, 2007, total debt outstanding was $201,369, including current maturities of $965. The total debt outstanding consisted of $175,000 under the Notes, $20,725 of debt secured by real estate and $5,644 of capital leases.

6. Earnings Per Share

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

	Three Months Ended March 31,	
	2007	**2006**
Net earnings	$ 38,211	$ 8,766
Shares used in computing per share amounts:		
Weighted average number of common shares outstanding	43,433,319	42,987,892
Common stock equivalents (as determined by applying the treasury stock method)	1,490,021	1,762,379
Weighted average number of common shares and potential dilutive common shares outstanding	44,923,340	44,750,271
Basic earnings per common share	$ 0.88	$ 0.20
Diluted earnings per common share	$ 0.85	$ 0.20

The calculation of diluted earnings per common share for the three months ended March 31, 2007 and 2006 excludes the impact of 2,246,850 and 150,900 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

7. 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 three months ended March 31, 2007, the Company repurchased 38,100 shares at an average price of $22.43 and an aggregate cost of $854.

8. Contingencies

As previously disclosed, two class action lawsuits were filed against the Company and certain of its officers and directors in the United States District Court for the Eastern District of Missouri, one in July 2006, or the July Class Action Lawsuit, and one in August 2006, or the August Class Action Lawsuit. The July Class Action Lawsuit and the August Class Action Lawsuit were consolidated on November 2, 2006 and an amended consolidated complaint was filed in the United States District Court for the Eastern District of Missouri on January 17, 2007, referred to as the Consolidated Class Action Lawsuit. The Consolidated Class Action Lawsuit alleges, on behalf of purchasers of the Company's common stock from April 25, 2006 through July 17, 2006, that the Company and certain of its officers and directors violated federal securities laws by issuing a series of materially false statements prior to the announcement of its fiscal 2006 second quarter results. According to the Consolidated Class Action Lawsuit, these allegedly materially false statements had the effect of artificially inflating the price of the Company's common stock, which subsequently dropped after the issuance of a press release announcing the Company's preliminary fiscal 2006 second quarter earnings and revised guidance. The Company believes the case is without merit and has filed a motion to dismiss the Consolidated Class Action Lawsuit.

Additionally, in August 2006, a separate derivative action was filed on behalf of Centene Corporation against the Company and certain of its officers and directors in the United States District Court for the Eastern District of Missouri. Plaintiff purports to bring suit derivatively on behalf of the Company against the Company's directors for breach of fiduciary duties, gross mismanagement and waste of corporate assets by reason of the directors' alleged failure to correct the misstatements alleged in the Consolidated Class Action Lawsuits discussed above. The derivative complaint largely repeats the allegations in the Consolidated Class Action Lawsuits. Based on discussions that have been held with plaintiff's counsel, it is the Company's understanding that plaintiff does not intend to pursue this action until the Consolidated Class Action Lawsuits proceed past the dismissal stage. Although this matter is in its early stages and no precise prediction of its outcome can be made, the Company believes the case is without merit and plans to vigorously defend against this lawsuit.

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

9. Segment Information

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

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

Segment information for the three months ended March 31, 2007, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 613,063	$ 57,772	$ —	$ 670,835
Revenue from internal customers	18,888	98,719	(117,607)	—
Total revenue	$ 631,951	$ 156,491	$ (117,607)	$ 670,835
Earnings from operations	$ 11,483	$ 5,668	$ —	$ 17,151

Segment information for the three months ended March 31, 2006, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 410,981	$ 44,097	$ —	$ 455,078
Revenue from internal customers	20,773	17,677	(38,450)	—
Total revenue	$ 431,754	$ 61,774	$ (38,450)	$ 455,078
Earnings from operations	$ 12,091	$ 505	$ —	$ 12,596

10. 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 March 31,	
	2007	2006
Net earnings	$ 38,211	$ 8,766
Reclassification adjustment, net of tax	34	13
Change in unrealized gain (loss) on investments, net of tax	292	(407)
Total comprehensive earnings	$ 38,537	$ 8,372

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, 2006. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under" Item 1A. Risk Factors."

OVERVIEW

We are a multi-line healthcare enterprise operating in two segments. Our Medicaid Managed Care segment provides Medicaid and Medicaid-related programs to organizations and individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program, or SCHIP, and, Supplemental Security Income including Aged, Blind or Disabled programs, or SSI. Our Specialty Services segment provides specialty services, including behavioral health, disease management, long-term care programs, managed vision, nurse triage, pharmacy benefits management and treatment compliance, to state programs, healthcare organizations and other commercial organizations, as well as to our own subsidiaries on market-based terms.

Our Medicaid contract in Kansas terminated effective December 31, 2006, and we sold the operating assets of FirstGuard Health Plan, Inc., our Missouri health plan, effective February 1, 2007.

Our first quarter performance for 2007 is summarized as follows:

- Quarter-end Medicaid Managed Care membership of 1,103,300.
- Total revenues of $670.8 million, a 47.4% increase over the comparable period in 2006.
- Medicaid and SCHIP health benefits ratio, or HBR, of 82.3%, SSI HBR of 86.3%, Specialty Services HBR of 79.3%.
- Medicaid Managed Care general and administrative, or G&A, expense ratio of 13.0% and Specialty Services G&A ratio of 15.8%.
- Operating earnings of $17.2 million.
- Diluted earnings per share of $0.85, including an after-tax benefit of $26.6 million, or $0.59 per share, for FirstGuard activity.
- Operating cash flows of $36.0 million.

Over the last year we have experienced membership and revenue growth in our Medicaid Managed Care segment including membership growth of 26.1% since March 31, 2006. The following new contracts and acquisitions contributed to our growth:

- In February 2007, we began managing care for SSI recipients in the San Antonio and Corpus Christi markets of Texas with 28,700 members at March 31, 2007.
- In January, February, and March 2007, we began managing care for SSI members in the Northeast, Southwest, and Northwest regions of Ohio, respectively, with 10,700 members at March 31, 2007. Implementation took place in the East Central region in April 2007.
- In September 2006, we expanded operations in Texas to include Medicaid and SCHIP members in the Corpus Christi, Austin and Lubbock markets, with 22,300 members at March 31, 2007.
- In Georgia, we began managing care for Medicaid and SCHIP members in the Atlanta and Central regions in June 2006 and the Southwest region in September 2006. At March 31, 2007, our membership in Georgia was 291,300.
- We began operating under new contracts with the State of Ohio to manage care for Medicaid members by entering seven new counties in the East Central market in July 2006, and 17 new counties in the Northwest market in October 2006, with 60,700 members at March 31, 2007.
- In June 2006, we acquired MediPlan Corporation, or MediPlan, and began managing care for additional Medicaid members in Ohio with 13,400 members at March 31, 2007. The results of operations of this entity are included in our consolidated financial statements beginning June 1, 2006.

We have been awarded the following new business opportunities to expand our operations:

— During the first quarter of 2007, we finalized the contractual terms of the Comprehensive Health Care for Children in Foster Care program award with the Texas Health and Human Services Commission (HHSC). This statewide program will provide managed care services to participants in the Texas Foster Care program. Membership operations are expected to commence in the fourth quarter of 2007.

— In April 2007, we acquired PhyTrust of South Carolina, LLC, a physician-driven company that serves over 30,000 members.

The following new contracts and acquisitions contributed to growth of our Specialty Services segment:

— 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., or 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, or Cardium Health, a disease management company. The results of operations of this entity are included in our consolidated financial statements beginning May 9, 2006.

RESULTS OF OPERATIONS AND KEY METRICS

Three Months Ended March 31, 2007 Compared to Three Months Ended March 31, 2006

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

	Three Months Ended March 31,		
	2007	2006	% Change 2006-2007
Premium revenue	$ 649.2	$ 435.6	49.1%
Service revenue	21.6	19.5	10.6%
Total revenues	670.8	455.1	47.4%
Medical costs	535.4	361.7	48.0%
Cost of services	15.6	15.6	0.3%
General and administrative expenses	106.9	65.2	63.8%
Gain on sale of FirstGuard Missouri	(4.2)	—	—%
Earnings from operations	17.2	12.6	36.2%
Investment and other income, net	1.3	1.5	(11.2)%
Earnings before income taxes	18.5	14.1	31.0%
Income tax (benefit) expense	(19.7)	5.3	(466.5)%
Net earnings	$ 38.2	$ 8.8	335.9%
Diluted earnings per common share	$ 0.85	$ 0.20	325.0%

Revenues and Revenue Recognition

Our Medicaid Managed Care segment generates revenues primarily from premiums we receive from the states in which we operate health plans. We receive a fixed premium per member per month pursuant to our state contracts. We generally receive premium payments during the month we provide services and recognize premium revenue during the period in which we are obligated to provide services to our members. Some states enact premium taxes or similar assessments, collectively, premium taxes, and these taxes are recorded as a component of revenues and general and administrative expenses (gross). Premium taxes totaled $18.2 million in the three months ended March 31, 2007, compared to $4.3 million for the comparable period in 2006. 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 state programs, healthcare organizations, and other commercial organizations, as well as from our own subsidiaries on market-based terms. Revenues are recognized when the related services are provided or as ratably earned over the covered period of services.

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

Our total revenue increased year over year primarily through 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 March 31, 2006 to March 31, 2007, we increased our total membership by 26.1%. The following table sets forth our membership by state in our Medicaid Managed Care segment:

	March 31,	
	2007	**2006**
Georgia	291,300	—
Indiana	176,700	193,000
New Jersey	59,100	57,500
Ohio	118,300	59,000
Texas	318,500	237,500
Wisconsin	139,400	175,100
Subtotal	1,103,300	722,100
Kansas and Missouri	—	152,700
Total	1,103,300	874,800

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

	March 31,	
	2007	**2006**
Medicaid	839,600	574,300
SCHIP	211,200	132,000
SSI	52,500	15,800
Subtotal	1,103,300	722,100
Kansas and Missouri Medicaid/SCHIP members	—	152,700
Total	1,103,300	874,800

From March 31, 2006 to March 31, 2007, we increased our membership through the commencement of operations in the Atlanta and Central regions of Georgia in June 2006 and in the Southwest region in September 2006, respectively, under our subsidiary, Peach State Health Plan. We increased our Medicaid membership in Ohio through the MediPlan acquisition, adding members under our new contract in the East Central and Northwest markets. We also increased our SSI membership in Ohio with the commencement of our new contract to serve Aged, Blind or Disabled members. In Texas, we increased our membership through new Medicaid, SCHIP and SSI contracts in the Corpus Christi, Austin, and Lubbock markets. The premium revenue for a SSI member is higher than a Medicaid / SCHIP member. For example, in Ohio the per member per month, or pmpm, premium for a SSI member averages approximately $1,100. In Texas, the SSI pmpm averages approximately $410. The pmpm revenue for a Medicaid member in our states' averages approximately $190. Our membership decreased in Wisconsin because of more stringent state eligibility requirements for the Medicaid and SCHIP programs, eligibility administration issues and the termination of certain physician contracts associated with a high cost hospital system. Our membership decreased in Indiana primarily due to adjustments made to our provider network made in connection with our new state-wide contract. The revenue associated with our Kansas and Missouri health plans was $76.3 million for the quarter ended March 31, 2006.

2. Premium rate increases

During the three months ended March 31, 2007, we received premium rate increases ranging from 2.5% to 10.1%, or 2.2% on a composite basis across our markets.

3. Specialty Services segment growth

In May 2006, we expanded our disease management services through our acquisition of Cardium Health. In July 2006, we began offering managed vision care through our acquisition of OptiCare. In October 2006, our subsidiary, Bridgeway Health Solutions, began performing under our long-term care contract in Arizona. At March 31, 2007, our behavioral health company, Cenpatico, provided behavioral health services to 93,600 members in Arizona and 36,600 members in Kansas, compared to 92,300 members in Arizona and 39,200 members in Kansas, at March 31, 2006.

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. 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 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 health benefits ratio, or 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 March 31,	
	2007	**2006**
Medicaid and SCHIP	82.3%	82.8%
SSI	86.3	87.6
Specialty Services	79.3	84.1

Our Medicaid and SCHIP HBR for the three months ended March 31, 2007 was 82.3%, a decrease of 0.5% over 2006. The decrease is primarily attributable to increased premium taxes. Sequentially, our Medicaid and SCHIP HBR increased from 82.1% in the 2006 fourth quarter to 82.3% because of utilization seasonality.

The decrease in the SSI HBR for the three months ended March 31, 2007 reflects an increase in premium taxes, partially offset by the new business in our Ohio and Texas health plans.

The decrease in our Specialty Services HBR for the three months ended March 31, 2007 is caused by the diversification of business in that segment which now includes OptiCare, effective July 1, 2006, and Bridgeway, effective October 1, 2006.

Cost of Services

Our cost of services expense includes the pharmaceutical costs associated with our pharmacy benefit manager's external revenues. Cost of services also includes all direct costs to support the local functions responsible for generation of our services 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.

General and Administrative Expenses

Our general and administrative expenses, or G&A, primarily reflect wages and benefits, including stock compensation expense, and other administrative costs related to our health plans, specialty companies and centralized functions that support all of our business units. Our major centralized functions are finance, information systems and claims processing. Premium taxes are also classified as G&A expenses. G&A increased in the three months ended March 31, 2007 over the comparable period in 2006 primarily due to premium taxes and expenses for additional facilities and staff to support our growth, especially in Arizona and Georgia.

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 March 31,	
	2007	2006
Medicaid Managed Care	13.0%	11.9%
Specialty Services	15.8	22.3

The increase in the Medicaid Managed Care G&A expense ratio for the three months ended March 31, 2007 primarily reflects increased premium taxes. Premium taxes were $18.2 million in the 2007 first quarter and $4.3 million in the 2006 first quarter. This increase was offset by the leveraging of our expenses over higher revenues especially in our Georgia health plan. The first quarter of 2006 included $4.5 million of Georgia implementation costs for which there was no associated revenue until June 1, 2006. The first quarter of 2007 also includes $0.7 million of South Carolina start-up costs.

The Specialty Services G&A ratio varies depending on the nature of the services provided and will generally be higher than the Medicaid Managed Care G&A ratio. The decrease in the Specialty Services G&A ratio for the three months ended March 31, 2007 primarily reflects the overall leveraging of expense over higher revenues with the addition of Cardium Health, Opticare and Bridgeway in the last three quarters of 2006 and the growth of US Script's business since the acquisition in 2006.

Gain on Sale of FirstGuard Missouri

The sale of the operating assets of FirstGuard Missouri was completed effective February 1, 2007. Under the terms of the asset sale agreement, we received an initial payment upon the sale of FirstGuard Missouri resulting in a gain of $4.2 million in 2007. We may recognize additional gain in a subsequent period of 2007 because we are entitled to a second payment currently estimated at approximately $3 million, contingent upon the membership levels of the purchaser as of June 1, 2007. The goodwill associated with FirstGuard written off as part of the transaction was $6.0 million.

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 $1.0 million in the three months ended March 31, 2007 primarily as a result of an increase in market interest rates and larger investment balances offset by a $1.6 million asset write-off associated with the abandonment of the stock of our Kansas health plan. Interest expense increased $1.1 million primarily from increased debt.

Income Tax (Benefit) Expense

During the first quarter of 2007 we recognized a tax benefit of $29.9 million associated with the abandonment of the stock of our Kansas health plan resulting in a net tax benefit of $19.7 million despite having $18.5 million of pre-tax income. During the first quarter of 2007 we also recorded $4.2 million of income tax expense associated with the sale of FirstGuard Missouri. Excluding the effect of the Kansas health plan stock deduction and gain on sale of our Missouri health plan, our 2007 effective tax rate for the three months ended March 31, 2007 was 38.0% compared to 38.0% for the comparable period in 2006.

LIQUIDITY AND CAPITAL RESOURCES

We finance our activities primarily through operating cash flows and borrowings under our revolving credit facility. Our total operating activities provided cash of $36.0 million in the three months ended March 31, 2007 compared to $9.3 million in the comparable period in 2006. The increase in cash flow from operations primarily reflects a decrease in premium and related receivables primarily related to Kansas and Missouri receivables. Medical claims liabilities decreased $4.5 million in the 2007 first quarter reflecting the payment of Kansas and Missouri claims incurred in 2006 and accelerated payment of Georgia claims offset by increases due to new business in Ohio and Texas. We expect that the tax benefit we recorded associated with the abandonment of the stock of our Kansas health plan will result in reduced income tax payments totaling approximately $29.9 million over the next several quarters.

Our investing activities used cash of $17.4 million in the three months ended March 31, 2007 compared to $73.4 million in the comparable period in 2006. Our investing activities in 2007 consisted primarily of additions to the investment portfolios of our regulated subsidiaries. During 2006, our investing activities primarily consisted of the acquisition of US Script. Our investing activities in 2006 also included additions to the investment portfolios of our regulated subsidiaries. Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets within our investment guidelines. Net cash provided by and used in investing activities will fluctuate from year to year due to the timing of investment purchases, sales and maturities. As of March 31, 2007, our investment portfolio consisted primarily of fixed-income securities with an average duration of 1.5 years. Cash is invested in investment vehicles such as municipal bonds, corporate bonds, insurance contracts, commercial paper and instruments of the U.S. Treasury. The states in which we operate prescribe the types of instruments in which our regulated subsidiaries may invest their cash.

We spent $14.8 million and $14.1 million on capital assets in the three months ended March 31, 2007 and 2006, respectively, consisting primarily of software and hardware upgrades, and furniture, equipment and leasehold improvements related to office and market expansions. We anticipate spending an additional $65 million on additional capital expenditures in 2007 primarily related to system upgrades and market expansions.

We anticipate spending approximately $20 million for additional property in Clayton, Missouri related to our redevelopment agreement with the City of Clayton, Missouri. In the second quarter of 2006, our subsidiary executed a three-year, $25 million non-recourse revolving credit facility to finance the property already acquired or expected to be acquired under the redevelopment agreement. As of March 31, 2007, we had $8.4 million in borrowings outstanding under this credit facility.

Our primary purpose for the redevelopment agreement is to accommodate office expansion needs for future company growth. The total scope of the project includes building two new office towers and street-level retail space. We plan to occupy a portion of those towers. The total expected cost of the project is approximately $210 million, however, we expect our financial commitment to be limited to the acquired property discussed above and future lease costs.

Our financing activities provided cash of $22.3 million and $35.2 million in the three months ended March 31, 2007 and 2006, respectively. During 2007, our financing activities primarily related to proceeds from issuance of $175 million in senior notes as discussed below. During 2006, our financing activities primarily related to proceeds from borrowings under our credit facility. These borrowings were used primarily for our investing activities in conjunction with the acquisition of US Script.

At March 31, 2007, we had working capital, defined as current assets less current liabilities, of $90.1 million as compared to $63.9 million at December 31, 2006. We manage our short-term and long-term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short-term capital requirements as needed.

Cash, cash equivalents and short-term investments were $355.0 million at March 31, 2007 and $338.0 million at December 31, 2006. Long-term investments were $207.8 million at March 31, 2007 and $170.7 million at December 31, 2006, including restricted deposits of $25.6 million and $25.3 million, respectively. At March 31, 2007, cash and investments held by our unregulated entities totaled $71.8 million while cash and investments held by our regulated entities totaled $491.0 million.

We have a $300 million revolving credit agreement. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. There is a commitment fee on the unused portion of the agreement that ranges from 0.15% to 0.275% depending on the total debt to EBITDA ratio. The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt to EBITDA ratios and minimum tangible net worth. The agreement will expire in September 2011. As of March 31, 2007, we had no borrowings outstanding under the agreement and $24.5 million in letters of credit outstanding, leaving availability of $275.5 million. As of March 31, 2007, we were in compliance with all covenants.

In March 2007, we issued $175 million aggregate principal amount of our 7 ¼% Senior Notes due April 1, 2014. The Notes have not been registered under the Securities Act of 1933, as amended, however, we intend to register the Notes pursuant to a registration rights agreement with the initial purchasers. The agreement contains non-financial and financial covenants, including requiring a minimum fixed charge coverage ratio. Interest will be paid semi-annually beginning in October 2007. We used a portion of the net proceeds from the offering to refinance approximately $150.0 million of our existing indebtedness which was outstanding under our revolving credit facility. The additional proceeds will be used for general corporate purposes. As of March 31, 2007, we were in compliance with all covenants.

We have a stock repurchase program authorizing us to repurchase up to four million shares of common stock from time to time on the open market or through privately negotiated transactions. The repurchase program extends through October 31, 2007, but we reserve the right to suspend or discontinue the program at any time. During the three months ended March 31, 2007, we repurchased 38,100 shares at an average price of $22.43. We have established a trading plan with a registered broker to repurchase shares under certain market conditions.

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

During the three months ended March 31, 2007, we received a dividend of $26.1 million for the excess regulatory capital remaining in our Kansas health plan. We believe the cash and investments for FirstGuard are sufficient to satisfy the remaining liabilities for FirstGuard. We expect remaining excess funds, currently estimated to be $8 million to $10 million, will become available to us for general corporate purposes when our regulatory obligations have been satisfied.

There were no other material changes outside the ordinary course of business in lease obligations or other contractual obligations in the three months ended March 31, 2007. Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our credit facility will be sufficient to finance our operations and capital expenditures for at least 12 months from the date of this filing.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

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

Our regulated subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of March 31, 2007, our subsidiaries had aggregate statutory capital and surplus of $239.3 million, compared with the required minimum aggregate statutory capital and surplus requirements of $151.7 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 March 31, 2007, all of our health plans were in compliance with the risk-based capital requirements enacted in those states.

FORWARD-LOOKING STATEMENTS

All statements, other than statements of current or historical fact, contained in this filing are forward-looking statements. We have attempted to identify these statements by terminology including "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "target," "goal," "may," "will," "should," "can," "continue" and other similar words or expressions in connection with, among other things, any discussion of future operating or financial performance. In particular, these statements include statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, including those entitled "Management's Discussion and Analysis of Financial Condition and Results of Operations," Item 1. "Legal Proceedings" 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.

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

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

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

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

INVESTMENTS

As of March 31, 2007, we had short-term investments of $43.1 million and long-term investments of $207.8 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 March 31, 2007, the fair value of our fixed income investments would decrease by approximately $2.7 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.

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 March 31, 2007. 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 March 31, 2007, 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 March 31, 2007 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.***

As previously disclosed, two class action lawsuits were filed against us and certain of our officers and directors in the United States District Court for the Eastern District of Missouri, one in July 2006, or the July Class Action Lawsuit, and one in August 2006, or the August Class Action Lawsuit. The July Class Action Lawsuit and the August Class Action Lawsuit were consolidated on November 2, 2006 and an amended consolidated complaint was filed in the United States District Court for the Eastern District of Missouri on January 17, 2007, which we refer to as the Consolidated Class Action Lawsuit. The Consolidated Class Action Lawsuit alleges, on behalf of purchasers of our common stock from April 25, 2006 through July 17, 2006, that we and certain of our officers and directors violated federal securities laws by issuing a series of materially false statements prior to the announcement of our fiscal 2006 second quarter results. According to the Consolidated Class Action Lawsuit, these allegedly materially false statements had the effect of artificially inflating the price of our common stock, which subsequently dropped after the issuance of a press release announcing our preliminary fiscal 2006 second quarter earnings and revised guidance. We believe the case is without merit and have filed a motion to dismiss the Consolidated Class Action Lawsuit.

Additionally, in August 2006, a separate derivative action was filed on behalf of Centene Corporation against us and certain of our officers and directors in the United States District Court for the Eastern District of Missouri. Plaintiff purports to bring suit derivatively on behalf of the Company against the Company's directors for breach of fiduciary duties, gross mismanagement and waste of corporate assets by reason of the directors' alleged failure to correct the misstatements alleged in the Consolidated Class Action Lawsuits discussed above. The derivative complaint largely repeats the allegations in the Consolidated Class Action Lawsuits. Based on discussions that have been held with plaintiff's counsel, it is our understanding that plaintiff does not intend to pursue this action until the Consolidated Class Action Lawsuits proceed past the dismissal stage. Although this matter is in its early stages and no precise prediction of its outcome can be made, we believe the case is without merit and plan to vigorously defend against this lawsuit.

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

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

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

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

Risks Related to Being a Regulated Entity

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

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

For example, in August 2006, 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. States must provide information to measure improper payments in Medicaid managed care, as well as in fee-for-service Medicaid. Each state will be selected for review once every three years for each program. States are required to repay CMS the federal share of any overpayments identified.

On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 to reduce the size of the federal deficit. The Act reduces federal spending by nearly $40 billion over 5 years, including a $5 billion reduction in Medicaid. The Act reduces spending by cutting Medicaid payments for prescription drugs and gives states new power to reduce or reconfigure benefits. This law may also lead to lower Medicaid reimbursements in some states. The Bush administration's budget proposal for fiscal year 2008 proposes cutting Medicaid funding by $1.9 billion in legislative changes and by $1.5 billion in administrative changes, which would lead to $25.7 billion in funding reductions over five years when compared to the fiscal year 2007 levels. Additionally, the Bush administration's 2008 budget for SCHIP provides for yearly allotments at the fiscal year 2007 levels, plus an additional $5 billion over the five-year period, which some believe will result in a funding shortfall. 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 SCHIP is not reauthorized, our business could suffer.

The authorization for SCHIP expires at the end of federal fiscal year 2007. We cannot guarantee that federal funding of SCHIP will be reauthorized and if it is, what changes might be made to the program following reauthorization. If SCHIP is not reauthorized by September 30, 2007, we anticipate that Congress will pass legislation that will freeze federal funding at the current 2007 levels. Congress began the reauthorization process in early February, 2007. At this time, it is not clear whether the relevant congressional committees of jurisdiction over this program will be able to reach agreement on an SCHIP reauthorization package that could cost $50 billion in additional federal spending.

Several states face a shortfall in federal SCHIP funding, which could have an impact on our business.

States receive matching funds from the federal government to pay for their SCHIP programs, which matching funds have a per state annual cap. It is predicted that two states in which we have SCHIP contracts, Georgia and New Jersey, will spend all of their federal allocation for fiscal year 2007 prior to the end of the year. In December 2006, Congress passed legislation that will redistribute funds that were not spent in prior years to the states that are facing these shortfalls. The Congressional Research Service estimates that this legislation will delay the shortfall to the first part of May 2007. We cannot predict whether the U.S. Congress will appropriate additional funds or take other legislative action to cover the shortfalls. Further, we cannot predict if states will provide additional funding to cover the federal shortfall. Certain of our contracts are subject to renewal this year and we cannot guarantee that they will be renewed and if renewed, whether the terms will be modified. If any of the contracts are not renewed or if any state delays paying us or fails to pay the full amount owed due to the shortfall, our business could suffer.

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 June 30, 2007 and September 30, 2011. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. For example, on August 25, 2006, we received notification from the Kansas Health Policy Authority that FirstGuard Health Plan Kansas, Inc.'s contract with the state would not be renewed or extended, and as a result, our contract ended on December 31, 2006. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds. 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.

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

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

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

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

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

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

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

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

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

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 $25.7 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 the Atlanta and Central regions of Georgia on June 1, 2006 and the Southwest region of Georgia on September 1, 2006 and have based our estimates on state provided historical actuarial data and limited 2006 actual incurred and received data. From time to time in the past, our actual results have varied from our estimates, particularly in times of significant changes in the number of our members. Our failure to estimate IBNR accurately may also affect our ability to take timely corrective actions, further harming our results.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Operations in Georgia, Indiana, Kansas, Texas and Wisconsin have accounted for most of our premium revenues to date. For example, our Medicaid contract with Kansas, which terminated December 31, 2006, together with our Medicaid contract with Missouri accounted for $317.0 million in revenue for the year ended December 31, 2006. If we were unable to continue to operate in each of these other 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. 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 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 require significant attention from our management. For example, we have been named in two recently-filed securities class action lawsuits that are now consolidated. 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.

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

Issuer Purchases of Equity Securities [1]
First Quarter 2007

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
January 1 - January 31, 2007	—	$ —	—	3,602,600
February 1 - February 28, 2007	13,100	23.66	13,100	3,589,500
March 1 - March 31, 2007	25,000	21.78	25,000	3,564,500
TOTAL	38,100	$ 22.43	38,100	3,564,500

[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 March 31, 2007, 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
4.1	Indenture for the 7 ¼% Senior Notes due 2014 dated March 22, 2007 among Centene Corporation and The Bank of New York Trust Company, N.A., as trustee, incorporated herein by reference to Exhibit 4.1 of Form 8-K filed March 23, 2007.
10.1	Registration Rights Agreement for the 7 ¼% Senior Notes due 2014 dated as of March 22, 2007, among the Company and Banc of America Securities LLC, Wachovia Capital Markets, LLC, Merrill Lynch, Pierce, Fenner & Smith Incorporated, ABN AMRO Incorporated, Allen & Company LLC and Goldman, Sachs & Co., as initial purchasers, incorporated herein by reference to Exhibit 10.1 of Form 8-K filed March 23, 2007.
10.2	Second Amendment to the contract for Medicaid/Badger Care HMO Services between Managed Health Services Insurance Corp. and Wisconsin Department of Heath and Family Services, incorporated herein by reference to Exhibit 10.1b of Form 10-K filed February 23, 2007.
10.3	Contract between the Office of the Medicaid Policy and Planning, the Office of the Children's Health Insurance Program and Coordinated Care Corporation Indiana, Inc., incorporated herein by reference to Exhibit 10.2 of Form 10-k filed February 23, 2007.
10.4	Centene Corporation Employee Deferred Compensation Plan.
12.1	Computation of ratio of earnings to fixed charges.
31.1	Certification of Chairman, President and Chief Executive Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of 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, President and Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Senior Vice President, Chief Financial Officer 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 April 24, 2007.

CENTENE CORPORATION

By: /s/ MICHAEL F. NEIDORFF

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

By: /s/ J. PER BRODIN

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

CENTENE CORPORATION EMPLOYEE DEFERRED COMPENSATION PLAN

ARTICLE I
PURPOSE AND EFFECTIVE DATE

The purpose of the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan ("Plan") is to aid Centene Corporation and its subsidiaries in retaining and attracting executive employees by providing them with tax deferred savings opportunities. The Plan provides a select group of management and highly compensated employees within the meaning of Sections 201(2), 301(a)(3) and 401(a)(1) of the Employee Retirement Income Security Act of 1974, as amended (ERISA) of Centene Corporation with the opportunity to elect to defer receipt of specified portions of compensation, and to have these deferred amounts treated as if invested in specified hypothetical investment benchmarks. The Plan shall be effective for deferral elections made hereunder on or after June 1, 2002.

ARTICLE II
DEFINITIONS

For the purposes of this Plan, the following words and phrases shall have the meanings indicated, unless the context clearly indicates otherwise:

Section 2.01
Administrative Committee. "Administrative Committee" means the committee appointed by the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee of the Board.

Section 2.02
Base Salary. "Base Salary" means the base rate of cash compensation paid by the Company to or for the benefit of a Participant for services rendered or labor performed while a Participant, including base pay a Participant could have received in cash in lieu of (A) deferrals pursuant to Section 4.02 and (B) contributions made on his behalf to any qualified plan maintained by the Company or to any cafeteria plan under Section 125 of the Internal Revenue Code maintained by the Company.

Section 2.03
Base Salary Deferral. "Base Salary Deferral" means the amount of a Participant's Base Salary which the Participant elects to have withheld on a pre-tax basis from his Base Salary and credited to his Deferral Account pursuant to Section 4.02.

Section 2.04
Beneficiary. "Beneficiary" means the person, persons or entity designated by the Participant to receive any benefits payable under the Plan pursuant to Article IX.
Board. "Board" means the Board of Directors of Centene Corporation.

Section 2.06
Code. "Code" shall mean the Internal Revenue Code of 1986, as amended. References to any provision of the Code or regulation (including a proposed regulation) thereunder shall include any successor provisions or regulations.

Section 2.07
Company. "Company" means Centene Corporation, its successors, any subsidiary or affiliated organizations authorized by the Board or the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee to participate in the Plan and any organization into which or with which Centene Corporation may merge or consolidate or to which all or substantially all of its assets may be transferred.

Section 2.08
Deferral Account. "Deferral Account" means the account maintained on the books of the Administrative Committee for each Participant pursuant to Article VI.

Section 2.10
Deferral Period. "Deferral Period" is defined in Section 4.02.

Section 2.11
Deferred Amount. "Deferred Amount" is defined in Section 4.02.

Section 2.12
Designee. "Designee" shall mean the Company's senior human resources officers or
other individuals to whom the Committee has delegated the authority to take action under the Plan. Wherever Committee is referenced in the plan, it shall be deemed to also refer to Designee.

Section 2.13
Disability. "Disability" means eligibility for disability benefits under the terms of the Company's Long-Term Disability Plan maintained by the Company.

Section 2.14
Eligible Compensation. "Eligible Compensation" means any Base Salary, Incentive Compensation, Bonuses and/or restricted stock otherwise payable with respect to a Plan Year.

Section 2.15
ERISA."ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

Section 2.16
Form of Payment. "Form of Payment" means payment in one lump sum or in substantially equal annual installments of 2 to 15 years.

Section 2.17
Hardship Withdrawal. "Hardship Withdrawal" means the early payment of all or part of the balance in a Deferral Account(s) in the event of an Unforeseeable Emergency.

Section 2.18
Hypothetical Investment Benchmark. "Hypothetical Investment Benchmark" shall mean the phantom investment benchmarks which are used to measure the return credited to a Participant's Deferral Account.

Section 2.19
Incentive Compensation. "Incentive Compensation" means the amount awarded to a Participant for a Plan Year under any incentive plan maintained by the Company.

Section 2.20
Incentive Deferral. "Incentive Deferral" means the amount of a Participant's Incentive Compensation which the Participant elects to have withheld on a pre-tax basis from his Incentive Compensation and credited to his account pursuant to Section 4.02.

Section 2.21
Matching Contribution. "Matching Contribution" means the amount of annual matching contribution that the Company will make to the plan.

Section 2.22
Participant. "Participant" means any individual who is eligible or makes an election to participate in this Plan and who elects to participate by filing a Participation Agreement as provided in Article IV.

Section 2.23
Participation Agreement."Participation Agreement" means an agreement filed by a Participant in accordance with Article IV.

Section 2.24
Plan Year. "Plan Year" means a twelve-month period beginning January 1 and ending the following December 31.

Section 2.25
Retirement. "Retirement" means retirement of a Participant from the Company after attaining age 65 or age 55 with at least 5 years of service (in accordance with the method of determining years of service adopted by the Company).

Section 2.26
Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee. "Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee" means the compensation committee of the Board.

Section 2.27
Termination of Employment. "Termination of Employment" means the cessation of a Participant's services as a full-time employee of the Company for any reason other than Retirement.

Section 2.28
Unforeseeable Emergency."Unforeseeable Emergency" means severe financial hardship to the Participant resulting from a sudden and unexpected illness or accident of the Participant or a dependent of the Participant, loss of the Participant's property due to casualty, or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the Participant.

Section 2.29
Valuation Date. "Valuation Date" means the last day of each calendar month or such other date as the Administrative Committee in its sole discretion may determine.

ARTICLE III
ADMINISTRATION

Section 3.01
Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee and Administrative Committee Duties. This Plan shall be administered by the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee. A majority of the members of the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee shall constitute a quorum for the transaction of business. All resolutions or other action taken by the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee shall be by a vote of a majority of its members present at any meeting or, without a meeting, by an instrument in writing

signed by all its members. Members of the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee may participate in a meeting of such committee by means of a conference telephone or similar communications equipment that enables all persons participating in the meeting to hear each other, and such participation in a meeting shall constitute presence in person at the meeting and waiver of notice of such meeting.

The Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee shall be responsible for the administration of this Plan and shall have all powers necessary to administer this Plan, including discretionary authority to determine eligibility for benefits and to decide claims under the terms of this Plan, except to the extent that any such powers are vested in any other person administering this Plan by the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee. The Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee may from time to time establish rules for the administration of this Plan, and it shall have the exclusive right to interpret this Plan and to decide any matters arising in connection with the administration and operation of this Plan. All rules, interpretations and decisions of the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee shall be conclusive and binding on the Company, Participants and Beneficiaries.

The Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee has delegated to the Administrative Committee responsibility for performing certain administrative and ministerial functions under this Plan. The Administrative Committee shall be responsible for determining in the first instance issues related to eligibility, Hypothetical Investment Benchmarks, distribution of Deferred Amounts, determination of account balances, crediting of hypothetical earnings and debiting of hypothetical losses and of distributions, in-service withdrawals, deferral elections and any other duties concerning the day-to-day operation of this Plan. The Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee shall have discretion to delegate to the Administrative Committee such additional duties as it may determine. The Administrative Committee may designate one of its members as a chairperson and may retain and supervise outside providers, third party administrators, record keepers and professionals (including in-house professionals) to perform any or all of the duties delegated to it hereunder.

Neither the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee nor a member of the Board nor any member of the Administrative Committee shall be liable for any act or action hereunder, whether of omission or commission, by any other member or employee or by any agent to whom duties in connection with the administration of this Plan have been delegated or for anything done or omitted to be done in connection with this Plan. The Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee and the Administrative Committee shall keep records of all of their respective proceedings and the Administrative Committee shall keep records of all payments made to Participants or Beneficiaries and payments made for expenses or otherwise.

The Company shall, to the fullest extent permitted by law, indemnify each director, officer or employee of the Company (including the heirs, executors, administrators and other personal representatives of such person), each member of the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee and Administrative Committee against expenses (including attorneys' fees), judgments, fines, amounts paid in settlement, actually and reasonably incurred by such person in connection with any threatened, pending or actual suit, action or proceeding (whether civil, criminal, administrative or investigative in nature or otherwise) in which such person may be involved by reason of the fact that he or she is or was serving this Plan in any capacity at the request of the Company, the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee or Administrative Committee.

Any expense incurred by the Company, the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee or the Administrative Committee relative to the administration of this Plan shall be paid by the Company and/or may be deducted from the Deferral Accounts of the Participants as determined by the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee.

Section 3.02
Claim Procedure. If a Participant or Beneficiary makes a written request alleging a right to receive payments under this Plan or alleging a right to receive an adjustment in benefits being paid under this Plan, such actions shall be treated as a claim for benefits. All claims for benefits under this Plan shall be sent to the Administrative Committee. If the Administrative Committee determines that any individual who has claimed a right to receive benefits, or different benefits, under this Plan is not entitled to receive all or any part of the benefits claimed, the Administrative Committee shall inform the claimant in writing of such determination and the reasons therefor in terms calculated to be understood by the claimant. The notice shall be sent within 90 days of the claim unless the Administrative Committee determines that additional time, not exceeding 90 days, is needed and so notifies the Participant. The notice shall make specific reference to the pertinent Plan provisions on which the denial is based, and shall describe any additional material or information that is necessary. Such notice shall, in addition, inform the claimant of the procedure that the claimant should follow to take advantage of the review procedures set forth below in the event the claimant desires to contest the denial of the claim. The claimant may within 90 days thereafter submit in writing to the Administrative Committee a notice that the claimant contests the denial of his or her claim and desires a further review by the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee. The Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee shall within 60 days thereafter review the claim and authorize the claimant to review pertinent documents and submit issues and comments relating to the claim to the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee. The Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee will render a final decision on behalf of the Company with specific reasons therefor in writing and will transmit it to the claimant within 60 days of the written request for review, unless the Chairperson of the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee determines that additional time, not exceeding 60 days, is needed, and so notifies the Participant. If the Committee fails to respond to a claim filed in accordance with the foregoing within 60 days or any such extended period, the Company shall be deemed to have denied the claim.

ARTICLE IV
PARTICIPATION

Section 4.01
Participation. Participation in the Plan shall be limited to executives who (i) meet such eligibility criteria as the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee shall establish from time to time, and (ii) elect to participate in this Plan by filing a Participation Agreement with the Administrative Committee. A Participation Agreement must be filed prior to the December 31st immediately preceding the Plan Year for which it is effective. The Administrative Committee shall have the discretion to establish special deadlines regarding the filing of Participation Agreements for Participants.

Section 4.02
Contents of Participation Agreement. Subject to Article VIII, each Participation Agreement shall set forth: (i) the amount of Eligible Compensation for the Plan Year or performance period to which the Participation Agreement relates that is to be deferred under the Plan (the

"Deferred Amount"), expressed as either a dollar amount or a percentage of the Base Salary and Incentive Compensation for such Plan Year or performance period; provided, that the minimum Deferred Amount for any Plan Year or performance period shall not be less than 1%; (ii) the period after which payment of the Deferred Amount is to be made or begin to be made (the "Deferral Period"), which shall be the earlier of (A) a number of full years, not less than three, and (B) the period ending upon the Retirement or prior termination of employment of the Participant, and (iii) the form in which payments are to be made, which may be a lump sum or in substantially equal annual installments of 1 to 15 years.

Section 4.03

Modification or Revocation of Election by Participant. A Participant may not change the amount of his Base Salary Deferrals during a Plan Year. However, a Participant may discontinue a Base Salary Deferral election at any time by filing, on such forms and subject to such limitations and restrictions as the Administrative Committee may prescribe in its discretion, a revised Participation Agreement with the Administrative Committee. If approved by the Administrative Committee, revocation shall take effect as of the first payroll period next following its filing. If a Participant discontinues a Base Salary Deferral election during a Plan Year, he will not be permitted to elect to make Base Salary Deferrals again until the later of the next Plan Year or 12 months from the date of discontinuance. In addition, the Deferral Period may be extended if an amended Participation Agreement is filed with the Administrative Committee at least one full calendar year before the Deferral Period (as in effect before such amendment) ends; provided, that only one such amendment may be filed with respect to each Participation Agreement.

ARTICLE V
DEFERRED COMPENSATION

Section 5.01

Elective Deferred Compensation. The Deferred Amount of a Participant with respect to each Plan Year of participation in the Plan shall be credited by the Administrative Committee to the Participant's Deferral Account as and when such Deferred Amount would otherwise have been paid to the Participant. To the extent that the Company is required to withhold any taxes or other amounts from the Deferred Amount pursuant to any state, Federal or local law, such amounts shall be taken out of other compensation eligible to be paid to the Participant that is not deferred under this Plan.

Section 5.02

Vesting of Deferral Account. Except as provided in Section 7.02, a Participant shall be 100% vested in his/her Deferral Account at all times.

ARTICLE VI
MAINTENANCE AND INVESTMENT OF ACCOUNTS

Section 6.01

Maintenance of Accounts. Separate Deferral Accounts shall be maintained for each Participant. More than one Deferral Account may be maintained for a Participant as necessary to reflect (a) various Hypothetical Investment Benchmarks and/or (b) separate Participation Agreements specifying different Deferral Periods and/or forms of payment. A Participant's Deferral Account(s) shall be utilized solely as a device for the measurement and determination of the amounts to be paid to the Participant pursuant to this Plan, and shall not constitute or be treated as a trust fund of any kind. The Administrative Committee shall determine the balance of each Deferral Account, as of each Valuation Date, by adjusting the balance of such Deferral Account as of the immediately preceding Valuation Date to reflect changes in the value of the deemed investments thereof, credits and debits pursuant to Section 5.01 and Section 6.02 and distributions pursuant to Article VII with respect to such Deferral Account since the preceding Valuation Date.

Section 6.02

Hypothetical Investment Benchmarks. (a) Each Participant shall be entitled to direct the manner in which his/her Deferral Accounts will be deemed to be invested, selecting among the Hypothetical Investment Benchmarks specified in Appendix A hereto, as amended by the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee from time to time, and in accordance with such rules, regulations and procedures as the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee may establish from time to time. Notwithstanding anything to the contrary herein, earnings and losses based on a Participant's investment elections shall begin to accrue as of the date such Participant's Deferral Amounts are credited to his/her Deferral Accounts.

Section 6.03

Statement of Accounts. The Administrative Committee shall submit to each Participant quarterly statements of his/her Deferral Account(s), in such form as the Administrative Committee deems desirable, setting forth the balance to the credit of such Participant in his/her Deferral Account(s) as of the end of the most recently completed quarter.

ARTICLE VII
BENEFITS

Section 7.01

Time and Form of Payment. At the end of the Deferral Period for each Deferral Account, the Company shall pay to the Participant the balance of such Deferral Account at the time or times elected by the Participant in the applicable Participation Agreement; provided that if the Participant has elected to receive payments from a Deferral Account in a lump sum, the Company shall pay the balance in such Deferral Account (determined as of the most recent Valuation Date preceding the end of the Deferral Period) in a lump sum in cash as soon as practicable after the end of the Deferral Period. If the Participant has elected to receive payments from a Deferral Account in installments, the Company shall make annual cash only payments from such Deferral Account, each of which shall consist of an amount equal to (i) the balance of such Deferral Account as of the most recent Valuation Date preceding the payment date times (ii) a fraction, the numerator of which is one and the denominator of which is the number of remaining installments (including the installment being paid). The first such installment shall be paid as soon as practicable after the end of the Deferral Period and each subsequent installment shall be paid on or about the anniversary of such first payment. Each such installment shall be deemed to be made on a pro rata basis from each of the different deemed investments of the Deferral Account (if there is more than one such deemed investment).

Section 7.02

Matching Contribution. Each Participant who elects to make deferrals of Eligible Compensation to the Plan will receive a Matching Contribution equal to 50% of the first 6% of that Participant's deferred Eligible Compensation offset by any Matching Contributions made under the Participant's 401(k) plan. All Matching Contributions will be subject to Vesting as defined in 7.03. Matching Contributions will be credited to the Participant's Deferral Account in the first quarter following the year for which the Contributions were due. The Matching Contributions shall follow the Participant's Hypothetical Investment Benchmarks for the deferral of the Eligible Compensation to which it relates. The amount of the Matching Contribution may vary from payroll period to payroll period throughout the Plan Year, may be based on a formula which takes into account a Participant's overall compensation, and otherwise may be subject to maximum or minimum limitations. The Matching Contribution shall be invested among the same Hypothetical Investment Benchmarks as defined in 6.02 in the same proportion as the elections made by the participant governing the deferrals of the participant. The Matching Contribution shall be distributed to the

participant according to the election made by the participant governing his/her deferrals and will vest according to the provisions governing matching contributions in the Company's 401(k) plan.

Section 7.03

Matching Contribution Vesting. Participant's will vest in Matching Contributions as set forth under the Participant's 401(k) plan. The vesting schedule is:

Less than 1 year	0%
1 year	10%
2 years	30%
3 years	60%
4 years	80%
5 years or more	100%

Section 7.04
Retirement. Subject to Section 7.01 and Section 7.07 hereof, if a Participant has elected to have the balance of his/her Deferral Account distributed upon Retirement, the account balance of the Participant (determined as of the most recent Valuation Date preceding such Retirement) shall be distributed upon Retirement in installments or a lump sum in accordance with the Plan and as elected in the Participant Agreement.

Section 7.05
In-Service Distributions. Subject to Section 7.01 and Section 7.07 hereof, if a Participant has elected to defer Eligible Compensation under the Plan for a stated number of years, the account balance of the Participant (determined as of the most recent Valuation Date preceding such Deferral Period) shall be distributed in installments or a lump sum in accordance with the Plan and as elected in the Participant Agreement.

Section 7.06
Other Than Retirement. Notwithstanding the provisions of Section 7.05 and Section 7.06 hereof and any Participation Agreement, if a Participant dies, has a Termination of Employment or Disability prior to Retirement and prior to receiving full payment of his/her Deferral Account(s), the Company shall pay the remaining balance (determined as of the most recent Valuation Date preceding such event) to the Participant or the Participant's Beneficiary or Beneficiaries (as the case may be) in a lump sum in cash only (notwithstanding Section 7.01 hereof) as soon as practicable following the occurrence of such event, unless the Administrative Committee in its sole discretion determines otherwise. Subject to Section 6.02(a) hereof, the amount distributable under the preceding sentence of this Section 7.07 shall be based on the Participant's investments elections.

Section 7.07
Hardship Withdrawals. Notwithstanding the provisions of Section 7.01 and any Participation Agreement, a Participant shall be entitled to early payment of all or part of the balance in his/her Deferral Account(s) in the event of an Unforeseeable Emergency, in accordance with this Section 7.07. A distribution pursuant to this Section 7.07 may only be made to the extent reasonably needed to satisfy the Unforeseeable Emergency need, and may not be made if such need is or may be relieved (i) through reimbursement or compensation by insurance or otherwise, (ii) by liquidation of the Participant's assets to the extent such liquidation would not itself cause severe financial hardship, or (iii) by cessation of participation in the Plan. An application for an early payment under this Section 7.07 shall be made to the Administrative Committee in such form and in accordance with such procedures as the Administrative Committee shall determine from time to time. The determination of whether and in what amount and form a distribution will be permitted pursuant to this Section 7.07 shall be made by the Administrative Committee.

Section 7.08
Voluntary Early Withdrawal. Notwithstanding the provisions of Section 7.01 and any Participation Agreement, a Participant shall be entitled to elect to withdraw all of the balance in his/her Deferral Account(s) in accordance with this Section 7.08 by filing with the Administrative Committee such forms, in accordance with such procedures, as the Administrative Committee shall determine from time to time. As soon as practicable after receipt of such form by the Administrative Committee, the Company shall pay an amount equal to ninety percent of the balance in such Participant's Deferral Account(s) (determined as of the most recent Valuation Date preceding the date such election is filed) to the electing Participant in a lump sum in cash, and the Participant shall forfeit the remainder of such Deferral Account(s). All Participation Agreements previously filed by a Participant who elects to make a withdrawal under this Section 7.08 shall be null and void after such election is filed (including without limitation Participation Agreements with respect to Plan Years or performance periods that have not yet been completed), and such a Participant shall not thereafter be entitled to file any Participation Agreements under the Plan with respect to the first Plan Year that begins after such election is made.

Section 7.09
Withholding of Taxes. Notwithstanding any other provision of this Plan, the Company shall withhold from payments made hereunder any amounts required to be so withheld by any applicable law or regulation.

ARTICLE VIII
BENEFICIARY DESIGNATION

Section 8.01
Beneficiary Designation. Each Participant shall have the right, at any time, to designate any person, persons or entity as his Beneficiary or Beneficiaries. A Beneficiary designation shall be made, and may be amended, by the Participant by filing a written designation with the Administrative Committee, on such form and in accordance with such procedures as the Administrative Committee shall establish from time to time.

Section 8.02
No Beneficiary Designation. If a Participant fails to designate a Beneficiary as provided above, or if all designated Beneficiaries predecease the Participant, then the Participant's Beneficiary shall be deemed to be the Participant's estate.

ARTICLE IX
AMENDMENT AND TERMINATION OF PLAN

Section 9.01

Amendment. The Board or the Centene Corporation Voluntary Nonqualified Deferred Compensation Committee may at any time amend this Plan in whole or in part, provided, however, that no amendment shall be effective to decrease the balance in any Deferral Account as accrued at the time of such amendment, nor shall any amendment otherwise have a retroactive effect.

Section 9.02

Company's Right to Terminate. The Board or the Centene Corporation Voluntary Nonqualified Deferred Compensation Committee may at any time terminate the Plan with respect to future Participation Agreements. The Board or the Centene Corporation Voluntary Nonqualified Deferred Compensation Committee may also terminate the Plan in its entirety at any time for any reason, including without limitation if, in its judgment, the continuance of the Plan, the tax, accounting, or other effects thereof, or potential payments thereunder would not be in the best interests of the Company, and upon any such termination, the Company shall immediately pay to each Participant in a lump sum the accrued balance in his Deferral Account (determined as of the most recent Valuation Date preceding the termination date).

ARTICLE X
MISCELLANEOUS

Section 10.01

Unfunded Plan. This Plan is intended to be an unfunded plan maintained primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees, within the meaning of Sections 201, 301 and 401 of ERISA. All payments pursuant to the Plan shall be made from the general funds of the Company and no special or separate fund shall be established or other segregation of assets made to assure payment. No Participant or other person shall have under any circumstances any interest in any particular property or assets of the Company as a result of participating in the Plan. Notwithstanding the foregoing, the Company may (but shall not be obligated to) create one or more grantor trusts, the assets of which are subject to the claims of the Company's creditors, to assist it in accumulating funds to pay its obligations under the Plan.

Section 10.02

Nonassignability. Except as specifically set forth in the Plan with respect to the designation of Beneficiaries, neither a Participant nor any other person shall have any right to commute, sell, assign, transfer, pledge, anticipate, mortgage or otherwise encumber, transfer, hypothecate or convey in advance of actual receipt the amounts, if any, payable hereunder, or any part thereof, which are, and all rights to which are, expressly declared to be unassignable and non-transferable. No part of the amounts payable shall, prior to actual payment, be subject to seizure or sequestration for the payment of any debts, judgments, alimony or separate maintenance owed by a Participant or any other person, nor be transferable by operation of law in the event of a Participant's or any other person's bankruptcy or insolvency. Hypothetical Investment Benchmarks. (a) Each Participant shall be entitled to direct the manner in which his/her Deferral Accounts will be deemed to be invested, selecting among the Hypothetical Investment Benchmarks specified in Appendix A hereto, as amended by the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee from time to time, and in accordance with such rules, regulations and procedures as the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee may establish from time to time. Notwithstanding anything to the contrary herein, earnings and losses based on a Participant's investment elections shall begin to accrue as of the date such Participant's Deferral Amounts are credited to his/her Deferral Accounts.

Section 10.03

Validity and Severability. The invalidity or unenforceability of any provision of this Plan shall not affect the validity or enforceability of any other provision of this Plan, which shall remain in full force and effect, and any prohibition or unenforceability in any jurisdiction shall not invalidate or render unenforceable such provision in any other jurisdiction.

Section 10.04

Governing Law. The validity, interpretation, construction and performance of this Plan shall in all respects be governed by the laws of the State of Missouri, without reference to principles of conflict of law, except to the extent preempted by federal law.

Section 10.05

Employment Status. This Plan does not constitute a contract of employment or impose on the Participant or the Company any obligation for the Participant to remain an employee of the Company or change the status of the Participant's employment or the policies of the Company and its affiliates regarding termination of employment.

Section 10.06

Underlying Incentive Plans and Programs. Nothing in this Plan shall prevent the Company from modifying, amending or terminating the compensation or the incentive plans and programs pursuant to which cash awards are earned and which are deferred under this Plan.

Section 10.07

Severance. Notwithstanding anything to the contrary herein the Centene Corporation Voluntary Nonqualified Deferred Compensation Committee may, in its sole and exclusive discretion, determine that the Deferral Account of a Participant who has incurred a Termination of Employment and who receives or will receive severance payments from the Company shall be paid in installments, at such intervals as the Centene Corporation Voluntary Nonqualified Deferred Compensation Committee may decide.

[Attestation per board resolution]

Exhibit 12.1

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

	For the Three Months Ended	Year Ended December 31,				
	3/31/2007	**2006**	**2005**	**2004**	**2003**	**2002**
Earnings:						
Pre-tax earnings from continuing operations	$ 18,520	$ (21,652)	$ 85,856	$ 70,287	$ 51,893	$ 41,136
Addback:						
Fixed charges	4,218	15,573	6,506	2,489	1,232	915
Total earnings	$ 22,738	$ (6,079)	$ 92,362	$ 72,776	$ 53,125	$ 42,051
Fixed Charges:						
Interest expense	$ 3,132	$ 10,636	$ 3,990	$ 680	$ 194	$ 45
Interest component of rental payments (1)	1,086	4,937	2,516	1,809	1,038	870
Total fixed charges	$ 4,218	$ 15,573	$ 6,506	$ 2,489	$ 1,232	$ 915
Ratio of earnings to fixed charges	5.39	(0.39)	14.20	29.24	43.12	45.96
Dollar amount of deficiency	-	$ 21,652	-	-	-	-

(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 Rules 13a-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: April 24, 2007

/s/ Michael F. Neidorff

Michael F. Neidorff
Chairman, President 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 Rules 13a-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: April 24, 2007

/s/ J. Per Brodin

J. Per Brodin
Senior Vice President, Chief Financial Officer 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 March 31, 2007, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), the undersigned, Michael F. Neidorff, Chairman, President and Chief Executive Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities 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, President and Chief Executive Officer

(principal executive officer)

Dated: April 24, 2007

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 March 31, 2007, 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 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 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 and Treasurer
(principal financial and accounting officer)

Dated: April 24, 2007