SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

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

For the quarterly period ended March 31, 2006

OR

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

For the transition period from to

Commission file number 000-33395

Centene Corporation

(Exact name of registrant as specified in its charter)

Delaware *(State or other jurisdiction of incorporation or organization)*	**42-1406317** *(I.R.S. Employer Identification Number)*
7711 Carondelet Avenue, Suite 800 **St. Louis, Missouri** *(Address of principal executive offices)*	**63105** *(Zip Code)*

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

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

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

Large accelerated filer ☒ Accelerated filer ☐ Non-accelerated filer ☐

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

As of April 17, 2006, the registrant had 43,084,562 shares of common stock outstanding.

CENTENE CORPORATION

QUARTERLY REPORT ON FORM 10-Q

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PART I

FINANCIAL INFORMATION

ITEM 1. ***Financial Statements***

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS
(In thousands, except share data)

	March 31, 2006	December 31, 2005
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$118,512	$ 147,358
Premium and related receivables, net of allowances of $611 and $343, respectively	66,368	44,108
Short-term investments, at fair value (amortized cost $71,400 and $56,863, respectively)	71,172	56,700
Other current assets	24,992	24,439
Total current assets	281,044	272,605
Long-term investments, at fair value (amortized cost $130,189 and $126,039, respectively)	127,289	123,661
Restricted deposits, at fair value (amortized cost $23,081 and $22,821, respectively)	22,788	22,555
Property, software and equipment, net	82,853	67,199
Goodwill	196,986	157,278
Other intangible assets, net	19,341	17,368
Other assets	7,506	7,364
Total assets	$737,807	$ 668,030
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liabilities	$172,792	$ 170,514
Accounts payable and accrued expenses	47,779	29,790
Unearned revenue	12,494	13,648
Current portion of long-term debt and notes payable	1,712	699
Total current liabilities	234,777	214,651
Long-term debt	130,940	92,448
Other liabilities	7,841	8,883
Total liabilities	373,558	315,982
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; issued and outstanding 43,072,053 and 42,988,230 shares, respectively	43	43
Additional paid-in capital	195,669	191,840
Accumulated other comprehensive income:		
Unrealized loss on investments, net of tax	(2,148)	(1,754)
Retained earnings	170,685	161,919
Total stockholders' equity	364,249	352,048
Total liabilities and stockholders' equity	$737,807	$ 668,030

See notes to consolidated financial statements.

CENTENE CORPORATION AND SUBSIDIARIES

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

	Three Months Ended March 31, 2006	Three Months Ended March 31, 2005
	(Unaudited)	
Revenues:		
Premium	$ 435,562	$ 330,944
Service	19,516	1,432
Total revenues	455,078	332,376
Expenses:		
Medical costs	361,672	267,756
Cost of services	15,588	843
General and administrative expenses	65,222	42,459
Total operating expenses	442,482	311,058
Earnings from operations	12,596	21,318
Other income (expense):		
Investment and other income	3,540	2,120
Interest expense	(1,998)	(562)
Earnings before income taxes	14,138	22,876
Income tax expense	5,372	8,465
Net earnings	$ 8,766	$ 14,411
Earnings per share:		
Basic earnings per common share	$ 0.20	$ 0.35
Diluted earnings per common share	$ 0.20	$ 0.32
Weighted average number of shares outstanding:		
Basic	42,987,892	41,560,587
Diluted	44,750,271	44,861,989

See notes to consolidated financial statements.

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CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)

	Three Months Ended March 31,	
	2006	2005
	(Unaudited)	
Cash flows from operating activities:		
Net earnings	$ 8,766	$ 14,411
Adjustments to reconcile net earnings to net cash provided by operating activities —		
Depreciation and amortization	4,520	2,782
Excess tax benefits from stock compensation	—	2,871
Stock compensation expense	3,417	1,091
Loss (gain) on sale of investments	12	10
Loss on disposal of property and equipment	30	183
Deferred income taxes	232	(983)
Changes in assets and liabilities —		
Premium and related receivables	(15,812)	(5,512)
Other current assets	(2,894)	(4,268)
Other assets	(158)	(491)
Medical claims liabilities	2,278	11,602
Unearned revenue	(934)	(21)
Accounts payable and accrued expenses	9,937	(2,446)
Other operating activities	(51)	648
Net cash provided by operating activities	9,343	19,877
Cash flows from investing activities:		
Purchase of property, software and equipment	(14,136)	(3,665)
Purchase of investments	(53,194)	(21,767)
Sales and maturities of investments	33,827	27,542
Acquisitions, net of cash acquired	(39,912)	—
Net cash (used in) provided by investing activities	(73,415)	2,110
Cash flows from financing activities:		
Proceeds from exercise of stock options	2,139	1,390
Proceeds from borrowings	37,000	—
Payment of long-term debt and notes payable	(2,285)	(4,121)
Excess tax benefits from stock compensation	1,454	—
Common stock repurchases	(3,082)	—
Other financing activities	—	(85)
Net cash provided by (used in) financing activities	35,226	(2,816)
Net (decrease) increase in cash and cash equivalents	(28,846)	19,171
Cash and cash equivalents, beginning of period	147,358	84,105
Cash and cash equivalents, end of period	$ 118,512	$ 103,276
Interest paid	$ 2,037	$ 692
Income taxes paid	$ 911	$ 1,133
Supplemental schedule of non-cash financing activities:		
Property acquired under capital leases	$ 26	$ —

See notes to consolidated financial statements.

CENTENE CORPORATION AND SUBSIDIARIES

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

1. Organization

Centene Corporation (Centene or the Company) is a multi-line healthcare enterprise operating in two segments. The Medicaid Managed Care segment provides Medicaid and Medicaid-related programs to organizations and individuals through government subsidized programs, including Medicaid, Supplemental Security Income (SSI) and the State Children's Health Insurance Program (SCHIP). The Specialty Services segment operates through contracts with Centene health plans, as well as other healthcare organizations, state programs and other commercial organizations. These specialty services include behavioral health, disease management, nurse triage and treatment compliance. Effective January 2006, the Specialty Services segment also includes pharmacy benefits management through Centene's acquisition of US Script, Inc.

2. Basis of Presentation

The unaudited interim financial statements herein have been prepared by the Company pursuant to the rules and regulations of the Securities and Exchange Commission. The accompanying interim financial statements have been prepared under the presumption that users of the interim financial information have either read or have access to the audited financial statements for the fiscal year ended December 31, 2005. Accordingly, footnote disclosures, which would substantially duplicate the disclosures contained in the December 31, 2005 audited financial statements, have been omitted from these interim financial statements where appropriate. In the opinion of management, these financial statements reflect all adjustments, consisting only of normal recurring adjustments, which are necessary for a fair presentation of the results of the interim periods presented.

Certain 2005 amounts in the consolidated financial statements have been reclassified to conform to the 2006 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

3. Stock Incentive Plans

In December 2004, the Financial Accounting Standards Board (FASB) issued Statement of Financial Accounting Standards No. 123 (revised 2004), "Share Based Payment," (SFAS 123R). SFAS 123R establishes the accounting for transactions in which an entity pays for employee services in share-based payment transactions. SFAS 123R requires companies to measure the cost of employee services received in exchange for an award of equity instruments based on the grant-date fair value of the award. The fair value of employee share options and similar instruments is estimated using option-pricing models adjusted for the unique characteristics of those instruments. That cost is recognized over the period during which an employee is required to provide service in exchange for the award. The Company adopted SFAS 123R effective January 1, 2006, using the modified-prospective transition method. Under this method, compensation cost is recognized for awards granted and for awards modified, repurchased or cancelled in the period after adoption. Compensation cost is also recognized for the unvested portion of awards granted prior to adoption. Prior year financial statements are not restated. The Company's results for the three months ended March 31, 2006 include an additional $2,384 of general and administrative expenses relating to the adoption of SFAS 123R. Net earnings were reduced by $1,672, or $0.04 per basic and diluted share. Additionally, upon adoption of SFAS 123R, excess tax benefits related to stock compensation are presented as a cash inflow from financing activities. This change had the effect of decreasing cash flows from operating activities and increasing cash flows from financing activities by $1,454.

For the three months ended March 31, 2005, the Company accounted for stock based compensation plans under APB Opinion No. 25 "Accounting for Stock Issued to Employees." Compensation cost related to stock options issued to employees was recorded only if the grant-date market price of the underlying stock exceeded the exercise price. The following table illustrates the effect on net earnings and earnings per share if a fair value based method had been applied to all awards.

	2005
Net earnings	$14,411
Stock-based employee compensation expense included in net earnings, net of related tax effects	677
Stock-based employee compensation expense determined under fair value based method, net of related tax effects	(1,980)
Pro forma net earnings	$13,108
Basic earnings per common share:	
As reported	$ 0.35
Pro forma	0.32
Diluted earnings per common share:	
As reported	$ 0.32
Pro forma	0.29

The Company's stock incentive plans allow for the granting of restricted stock or restricted stock unit awards and options to purchase common stock. Both incentive stock options and nonqualified stock options can be awarded under the plans. No option will be exercisable for longer than ten years after the date of grant. The plans have 959,769 shares available for future awards. Compensation expense for stock options and restricted stock unit awards is recognized on a straight-line basis over the vesting period, generally three to five years for stock options and one to ten years for restricted stock or restricted stock unit awards. Certain awards provide for accelerated vesting if there is a change in control (as defined in the plans).

Option activity for the three months ended March 31, 2006 is summarized below:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic value	Weighted Average Remaining Contractual Term
Outstanding as of December 31, 2005	5,273,571	$ 15.79		
Granted	43,000	26.40		
Exercised	(194,061)	9.70		
Expired	(12,900)	25.82		
Forfeited	(197,700)	18.90		
Outstanding as of March 31, 2006	4,911,910	$ 15.98	$ 62,722	7.5
Exercisable as of March 31, 2006	1,900,184	$ 11.86	$ 32,014	6.6

The fair value of each option grant is estimated on the date of the grant using the Black-Scholes option-pricing model with the following assumptions: no dividend yield; expected volatility of 44% and 55%; risk-free interest rate of 4.5% and 4.0% and expected lives of 6.5 and 6.0 for the three months ended March 31, 2006 and 2005, respectively.

For the three months ended March 31, 2006, the expected life of each award granted was calculated using the "simplified method" in accordance with Staff Accounting Bulletin No. 107. For the three months ended March 31, 2005, the Company used a projected expected life for each award granted based on historical experience of employees' exercise behavior. For the three months ended March 31, 2006, expected volatility is primarily based on historical volatility levels along with the implied volatility of exchange traded options to purchase Centene common stock. For the three months ended March 31, 2005, expected volatility is based on historical volatility levels. The risk-free interest rate is based on the implied yield currently available on U.S. Treasury zero coupon issues with a remaining term equal to the expected life.

The weighted-average fair value of options granted during the three months ended March 31, 2006 and 2005 was $13.45 and $18.89, respectively. The total intrinsic value of options exercised during the three months ended March 31, 2006 and 2005 was $3,304 and $14,312, respectively.

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Non-vested restricted stock and restricted stock unit activity for the three months ended March 31, 2006 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Non-vested balance as of December 31, 2005	1,153,655	$ 25.20
Granted	1,000	26.23
Vested	(10,950)	33.90
Forfeited	(2,400)	25.40
Non-vested balance as of March 31, 2006	1,141,305	$ 25.12

As of March 31, 2006 there was $46,094 of total unrecognized compensation cost related to non-vested share-based compensation arrangements granted under the plans; that cost is expected to be recognized over a weighted-average period of four years.

4. Acquisitions

US Script

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

The preliminary purchase price allocation resulted in estimated identifiable intangible assets of $5,000 and associated deferred tax liabilities of $2,000 and goodwill of approximately $37,600. The identifiable intangible assets have an estimated useful life of five years. The acquired goodwill is not deductible for income tax purposes. Pro forma disclosures related to the acquisition have been excluded as immaterial.

AirLogix

Effective July 22, 2005, the Company acquired 100% of AirLogix, Inc., a disease management provider. The Company paid approximately $36,200 in cash and related transaction costs. If certain performance criteria are achieved, additional consideration of up to $5,000 may be paid. The results of operations for AirLogix are included in the consolidated financial statements since July 22, 2005.

The preliminary purchase price allocation resulted in estimated identified intangible assets of $2,800 and associated deferred tax liabilities of $1,100 and goodwill of approximately $32,200. The identifiable intangible assets have an estimated useful life of one to five years. The acquired goodwill is not deductible for income tax purposes. Pro forma disclosures related to the acquisition have been excluded as immaterial.

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5. Earnings Per Share

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

	Three Months Ended March 31,	
	2006	2005
Net earnings	$ 8,766	$ 14,411
Shares used in computing per share amounts:		
Weighted average number of common shares outstanding	42,987,892	41,560,587
Common stock equivalents (as determined by applying the treasury stock method)	1,762,379	3,301,402
Weighted average number of common shares and potential dilutive common shares outstanding	44,750,271	44,861,989
Basic earnings per common share	$ 0.20	$ 0.35
Diluted earnings per common share	$ 0.20	$ 0.32

The calculation of diluted earnings per common share for the three months ended March 31, 2006 and 2005 excludes the impact of 150,900 and 128,933 shares, respectively, related to stock options, unvested restricted stock and restricted stock units which are anti-dilutive.

6. 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 anytime. During the three months ended March 31, 2006, the Company repurchased 129,700 shares at an average price of $23.76 and an aggregate cost of $3,082.

7. Contingencies

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

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8. Segment Information

Centene operates in two segments: Medicaid Managed Care and Specialty Services. The Medicaid Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene's specialty companies including behavioral health, disease management, 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 makers to evaluate all results of operations.

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

Segment information for the three months ended March 31, 2005, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 330,543	$ 1,833	$ —	$ 332,376
Revenue from internal customers	17,048	8,084	(25,132)	—
Total revenue	$ 347,591	$ 9,917	$ (25,132)	$ 332,376
Earnings from operations	$ 21,330	$ (12)	$ —	$ 21,318

Effective with the US Script acquisition, the Company reassessed the calculations used to determine the proportion of certain costs allocated among each of our two segments. This assessment included an evaluation of whether the costs should be allocated based on revenue, number of claims, or headcount measures and altered the proportion of certain general and administrative expenses. The altered percentages resulted in the allocation of an additional $3,125 to the Medicaid Managed Care segment than would have been allocated under the previous formulas.

9. 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,	
	2006	2005
Net earnings	$8,766	$ 14,411
Reclassification adjustment, net of tax	13	9
Change in unrealized losses on investments available for sale, net of tax	(407)	(1,200)
Total comprehensive earnings	$8,372	$ 13,220

ITEM 2. ***Management's Discussion and Analysis of Financial Condition and Results of Operations.***

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing, and in our annual report on Form 10-K for the year ended December 31, 2005. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth below under "Item 1A. Risk Factors."

OVERVIEW

We are a multi-line healthcare enterprise operating in two segments. Our Medicaid Managed Care segment provides Medicaid and Medicaid-related programs to organizations and individuals through government subsidized programs, including Medicaid, Supplemental Security Income (SSI) and the State Children's Health Insurance Program (SCHIP). Our Specialty Services segment operates through contracts with our health plans, as well as other healthcare organizations, state programs and other commercial organizations. These specialty services include behavioral health, disease management, nurse triage and treatment compliance. Effective January 2006, our specialty services also include pharmacy benefits management through our acquisition of US Script, Inc.

Our key 2006 first quarter performance indicators include:

- Quarter-end Medicaid Managed Care membership of 874,800.
- Revenues of $455.1 million, a 37% increase over the comparable period in 2005.
- Medicaid and SCHIP health benefits ratio (HBR) of 82.8%, SSI HBR of 87.6% and Specialty Services HBR of 84.1%.
- Medicaid Managed Care general and administrative (G&A) expense ratio of 11.9% and Specialty Services G&A ratio of 22.3%.
- Operating earnings of $12.6 million.
- Diluted earnings per share of $0.20.
- Operating cash flows of $9.3 million.

Over the last year we have experienced strong growth in our Medicaid Managed Care segment including membership growth of 12.5% since March 31, 2005. That growth was highlighted by the following:

- We increased our membership by 28.8% in Indiana.
- We increased our membership by 24.6% in Kansas.
- Effective May 1, 2005, we acquired certain Medicaid-related assets of SummaCare, Inc. for approximately $30.4 million. The results of operations of this entity are included in our consolidated financial statements beginning May 1, 2005.

Additionally, we have new contracts or preliminary contract awards to enter the Georgia market and expand our operations in Ohio and Texas.

- During the third quarter of 2005 we were awarded Medicaid contracts in Georgia by the Georgia Department of Community Health. Our subsidiary, Peach State Health Plan, Inc., will manage care for a portion of the Medicaid and SCHIP recipients in the Atlanta, Central and Southwest regions. Membership operations are scheduled to commence in June 2006.
- During the first quarter of 2006 we executed a definitive agreement to acquire MediPlan Corporation in Ohio for approximately $8.5 million. Additionally, we received preliminary notification of an award of Medicaid contracts by the State of Ohio, increasing counties served from two to 27. Roll-out dates for this expansion have not yet been established.
- During the fourth quarter of 2005 we were awarded contracts in Texas to expand our operations to the Corpus Christi market. Membership operations are scheduled to commence in September 2006.

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

- Effective January 2006 we acquired US Script, Inc., a pharmacy benefits manager (PBM), for $40.6 million. The results of operations of this entity are included in our consolidated financial statements beginning January 1, 2006.
- Effective July 22, 2005, we acquired AirLogix, Inc., a disease management provider, for a purchase price of approximately $36.2 million. The results of operations of this entity are included in our consolidated financial statements since July 22, 2005.
- Effective July 1, 2005, we began performing under our contract with the State of Arizona to facilitate the delivery of mental health and substance abuse services to behavioral health recipients in Arizona.

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RESULTS OF OPERATIONS AND KEY METRICS

Three Months Ended March 31, 2006 Compared to Three Months Ended March 31, 2005

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

	Three Months Ended March 31,		
	2006	2005	% Change 2005-2006
Premium revenue	$435.6	$331.0	31.6%
Service revenue	19.5	1.4	—
Total revenues	455.1	332.4	36.9%
Medical costs	361.7	267.8	35.1%
Cost of services	15.6	0.8	—
General and administrative expenses	65.2	42.5	53.6%
Earnings from operations	12.6	21.3	(40.9)%
Investment and other income, net	1.5	1.6	(1.0)%
Earnings before income taxes	14.1	22.9	(38.2)%
Income tax expense	5.3	8.5	(36.5)%
Net earnings	$ 8.8	$ 14.4	(39.2)%
Diluted earnings per common share	$ 0.20	$ 0.32	(37.5)%

Revenues and Revenue Recognition

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

Our Specialty Services segment generates revenues under contracts with state and local government entities, our health plans and third-party customers. Revenues are recognized when the related services are provided or as ratably earned over the covered period of service. For performance-based contracts, we do not recognize revenue subject to refund until data is sufficient to measure performance.

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

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

1. Membership growth

From March 31, 2005 to March 31, 2006, we increased our membership by 12.5%. The following table sets forth our membership by state in our Medicaid Managed Care segment:

	March 31,	
	2006	2005
Indiana	193,000	149,900
Kansas	118,200	94,900
Missouri	34,500	41,300
New Jersey	57,500	52,700
Ohio	59,000	23,900
Texas	237,500	243,700
Wisconsin	175,100	170,900
Total	874,800	777,300

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

	March 31,	
	2006	2005
Medicaid	683,700	588,100
SCHIP	175,300	178,500
SSI	15,800	10,700
Total	874,800	777,300

From March 31, 2005 to March 31, 2006, we increased our membership in Ohio through our acquisition of the Medicaid-related assets of SummaCare, Inc. Our membership increased in Indiana, New Jersey and Wisconsin from additions to our provider networks, expansion into SSI in Wisconsin, service of additional counties and growth in the overall number of Medicaid beneficiaries. In Kansas, we increased our membership by eliminating a ceiling on our total membership with the State. Our membership decreased in Missouri and Texas because of more stringent eligibility requirements for the Medicaid and SCHIP programs and eligibility administrative issues in Texas.

2. Premium rate increases

During the three months ended March 31, 2006, we received premium rate increases, net of increases related to premium tax enactments, ranging from 1.8% to 6.5%, or 2.2% on a composite basis across our markets.

3. Specialty Services segment growth

In 2005 we began performing under our behavioral health contracts with the States of Arizona and Kansas. At March 31, 2006, our behavioral health company, Cenpatico, provided behavioral health services to 92,300 members in Arizona, 39,200 members in Kansas and 699,100 members through contracts with our health plans compared to 35,400 members in Kansas and 588,400 members through contracts with our health plans at March 31, 2005. In July 2005 we began offering disease management services through our acquisition of AirLogix. Additionally, in January 2006 we began offering pharmacy benefits management services through our acquisition of US Script. The increase in service revenues reflects the acquisitions of AirLogix and US Script.

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 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,	
	2006	2005
Medicaid and SCHIP	82.8%	80.6%
SSI	87.6%	94.6%
Specialty Services	84.1%	133.5%

Our Medicaid and SCHIP HBR increased for the three months ended March 31, 2006 versus the comparable period in 2005 due to: (1) higher utilization trends in certain markets, especially in January 2006. Our February and March data indicates normalized levels of utilization; (2) an increase in pharmacy related costs, especially in our Indiana and, to a lesser extent, Ohio markets which increased our HBR by 0.7% as compared to the fourth quarter of 2005; and (3) expansion into new markets previously unmanaged by us. For example, we experienced higher cost trends in Indiana where we added membership in the second half of 2005 as the State expanded its Medicaid managed care program to include all Medicaid and SCHIP enrollees. Our Specialty Services HBR for 2006 includes the behavioral health contracts in Arizona and Kansas, while the 2005 results included only the first three months of our behavioral health contract in Kansas.

Cost of Services

Our cost of services expenses include all direct costs to support the local functions responsible for generation of our service revenues. These expenses consist of the salaries and wages of the physicians, therapists and teachers who provide the services and expenses related to facilities and equipment used to provide services. Cost of services also includes the pharmacy costs incurred by our PBM. The increase in cost of services year over year reflects the acquisitions of AirLogix and US Script.

General and Administrative Expenses

Our G&A expenses primarily reflect wages and benefits, including stock compensation expense, and other administrative costs related to health plans, specialty companies and our centralized functions that support all of our business units. Our major centralized functions are finance, information systems and claims processing. Premium taxes are also classified as G&A expenses. G&A expenses increased for the three months ended March 31, 2006 over the comparable period in 2005 primarily due to expenses for additional facilities and staff to support our growth, especially in Arizona and Georgia. The 2006 results include $4.7 million of implementation costs in Georgia and $2.4 million of stock compensation expense as a result of adopting SFAS 123R on January 1, 2006.

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

	Three Months Ended March 31,	
	2006	2005
Medicaid Managed Care	11.9%	10.8%
Specialty Services	22.3%	50.2%

The increase in the Medicaid Managed Care G&A expense ratio in 2006 reflects implementation costs in Georgia without any associated revenues, the adoption of SFAS 123R and the effect of new premium tax enactments. Premium taxes totaled $4.3 million and $1.7 million in the three months ended March 31, 2006 and 2005, respectively. Premium taxes had the effect of increasing our G&A ratio by 0.9% and 0.5% in the three months ended March 31, 2006 and 2005, respectively.

The Specialty Services G&A ratio varies depending on the nature of the services provided and will have a higher general and administrative expense ratio than the Medicaid Managed Care segment. The results for the three months ended March 31, 2006 reflect the operations of our behavioral health company in Arizona, and the acquisitions of US Script and AirLogix.

Effective with the US Script acquisition, we reassessed the calculations used to determine the proportion of certain costs allocated among each of our two segments. This assessment included an evaluation of whether the costs should be allocated based on revenue, number of claims, or headcount measures and altered the proportion of certain G&A costs. The altered percentages resulted in the allocation of an additional $3.1 million to the Medicaid Managed Care segment than would have been allocated under the previous formulas.

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 $1.4 million for the three months ended March 31, 2006 over the comparable period in 2005 as a result of an increase in market interest rates. Interest expense increased $1.4 million from increased borrowings under our credit facility.

Income Tax Expense

Our effective tax rate for the three months ended March 31, 2006 was 38.0%, compared to 37.0% for the comparable period in 2005. The increase was primarily due to the effect of recording the tax benefit associated with the incentive stock option component of stock compensation directly to equity, rather than in income tax expense, under SFAS 123R.

LIQUIDITY AND CAPITAL RESOURCES

We finance our activities primarily through operating cash flows and borrowings under our revolving credit facility. Our operating activities provided cash of $9.3 million in the three months ended March 31, 2006 compared to $19.9 million in the comparable period in 2005. The decline in cash flow from operations in 2006 reflects a greater increase in premium and related receivables and a lower increase in medical claims liabilities combined with a decline in net earnings. The greater increase in premium and related receivables reflects an increase in capitation receivables and in reimbursements due to us from providers including amounts due under capitated risk-sharing contracts. The increase in the premium and related receivables balance also reflects the acquisition of US Script. The lower increase in medical claims liabilities reflects information systems improvements to reduce our claims processing cycle time.

Our investing activities used cash of $73.4 million and provided cash of $2.1 million in the three months ended March 31, 2006 and 2005 respectively. During 2006, our investing activities primarily consisted of the acquisition of US Script. 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, 2006, 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 asset-backed securities, municipal bonds, corporate bonds, insurance contracts, commercial paper and instruments of the U.S. Treasury. The states in which we operate prescribe the types of instruments in which our regulated subsidiaries may invest their cash.

We spent $14.1 million and $3.7 million on capital assets in the three months ended March 31, 2006 and 2005, respectively. The expenditures in 2006 included $6.5 million for computer software. We anticipate spending an additional $35 million on capital expenditures in 2006 primarily related to information systems and our Georgia expansion.

The expenditures in 2006 also included $4.3 million for a property contiguous to our corporate headquarters as part of our redevelopment agreement with the City of Clayton, MO. In the second quarter of 2006, we expect to execute a three-year, $25 million unsecured credit facility to finance this property and other property related to the redevelopment agreement. We anticipate spending approximately $17 million for additional property in Clayton, MO related to this agreement.

Our financing activities provided cash of $35.2 million in the three months ended March 31, 2006 and used cash of $2.8 million in the three months ended March 31, 2005. During 2006, our financing activities primarily related to proceeds from borrowings under our Revolving Credit Agreement. These borrowings were used primarily for our investing activities in conjunction with the acquisition of US Script. During 2005, our financing cash flows primarily consisted of payments on our Revolving Credit Agreement.

At March 31, 2006, we had working capital, defined as current assets less current liabilities, of $46.3 million as compared to $58.0 million at December 31, 2005. Our investment policies are designed to provide liquidity and preserve capital. We manage our short-term and long-term investments to ensure that a sufficient portion is held in investments that are highly liquid and can be sold to fund short-term capital requirements as needed.

Cash, cash equivalents and short-term investments were $189.7 million at March 31, 2006 and $204.1 million at December 31, 2005. Long-term investments were $150.1 million at March 31, 2006 and $146.2 million at December 31, 2005, including restricted deposits of $22.8 million and $22.6 million, respectively. At March 31, 2006, cash and investments held by our unregulated entities totaled $25.8 million while cash and investments held by our regulated entities totaled $314.0 million.

We have an unsecured Revolving Credit Agreement with several lending institutions, for which LaSalle Bank National Association serves as administrative agent and co-lead arranger. The total amount available under the credit agreement is $200 million, including a sub-facility for letters of credit in an aggregate amount up to $50 million. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. Under our current capital structure, borrowings under the agreement bear interest at LIBOR plus 1.5%. This rate may change under differing capital structures over the life of the agreement. 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 on September 9, 2010 or on an earlier date in the instance of a default as defined in the agreement. As of March 31, 2006, we had $112.0 million in borrowings outstanding under the agreement and $15.0 million in letters of credit outstanding, leaving an availability of $73.0 million. As of March 31, 2006, we were in compliance with all covenants.

Our board of directors adopted a stock repurchase program authorizing us to repurchase up to 4,000,000 shares of common stock from time to time on the open market or through privately negotiated transactions. The repurchase program extends through

October 31, 2007, but we reserve the right to suspend or discontinue the program at any time. During the three months ended March 31, 2006, we repurchased 129,700 shares at an average price of $23.76. We have established a trading plan with a registered broker to repurchase shares under certain market conditions.

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

In January 2006, we executed a definitive agreement, subject to regulatory approvals, to acquire MediPlan Corporation for approximately $8.5 million in cash plus transaction costs. The acquisition is expected to close in the second quarter of 2006. In April 2006, we executed a definitive agreement, subject to regulatory approvals, to acquire the managed vision business of OptiCare Health Systems, Inc. for approximately $7.5 million in cash plus transaction costs. The acquisition is expected to close in the third quarter of 2006.

There were no other material changes outside the ordinary course of our business in lease obligations or other contractual obligations in the three months ended March 31, 2006. Based on our operating plan, we expect that our available funding will be sufficient to finance our operations, planned acquisitions of MediPlan Corporation and OptiCare Health Systems, Inc., and capital expenditures for at least 12 months from the date of this filing.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

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

Our subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of March 31, 2006, our subsidiaries had aggregate statutory capital and surplus of $182.1 million, compared with the required minimum aggregate statutory capital and surplus requirements of $93.4 million.

The National Association of Insurance Commissioners has adopted rules which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of March 31, 2006, our Georgia, Indiana, New Jersey, Ohio, Texas and Wisconsin health plans were in compliance with the risk-based capital requirements enacted in those States. If adopted by Kansas or Missouri, we believe we would be in compliance with the risk-based capital requirements for these subsidiaries. We continue to monitor the requirements in Kansas and Missouri and do not expect that they will have a material impact on our results of operations, financial position or cash flows.

FORWARD-LOOKING STATEMENTS

This filing contains forward-looking statements that relate to future events or our future financial performance. We have attempted to identify these statements by terminology including "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "goal," "may," "will," "should," "can," "continue" or the negative of these terms or other comparable terminology. These statements include statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, investments and the adequacy of our available cash resources. These statements may be found in the section of this filing entitled "Management's Discussion and Analysis of Financial Condition and Results of Operations." Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, including economic, regulatory, competitive and other factors that may cause our or our industry's actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

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

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

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

INVESTMENTS

As of March 31, 2006, we had short-term investments of $71.2 million and long-term investments of $150.1 million, including restricted deposits of $22.8 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, 2006, the fair value of our fixed income investments would decrease by approximately $3.0 million. Declines in interest rates over time will reduce our investment income.

INFLATION

Although the general rate of inflation has remained relatively stable and healthcare cost inflation has stabilized in recent years, the national healthcare cost inflation rate still exceeds the general inflation rate. We use various strategies to mitigate the negative effects of healthcare cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of healthcare services. Through these contracted care providers, our health plans emphasize preventive healthcare and appropriate use of specialty and hospital services.

While we currently believe our strategies to mitigate healthcare cost inflation will continue to be successful, competitive pressures, new healthcare and pharmaceutical product introductions, demands from healthcare providers and customers, applicable regulations or other factors may affect our ability to control the impact of healthcare cost increases.

COMPLIANCE COSTS

Federal and state regulations governing standards for electronic transactions, data security and confidentiality of patient information have been issued in recent years. Due to the uncertainty surrounding the regulatory requirements, we cannot be sure that the systems and programs that we have implemented will comply adequately with the security regulations that are ultimately adopted. Implementation of additional systems and programs may be required. Further, compliance with these regulations would require changes to many of the procedures we currently use to conduct our business, which may lead to additional costs that we have not yet identified. We do not know whether, or the extent to which, we will be able to recover our costs of complying with these new regulations from the states.

ITEM 4. ***Controls and Procedures.***

Evaluation of Disclosure Controls and Procedures - Our management, with the participation of our chief executive officer and chief financial officer, evaluated the effectiveness of our disclosure controls and procedures as of March 31, 2006. The term "disclosure controls and procedures," as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act, means controls and other procedures of a company that are designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the company's management, including its principal executive and principal financial officers, as appropriate to allow timely decisions regarding required disclosure. Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving their objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Based on the evaluation of our disclosure controls and procedures as of March 31, 2006, our chief executive officer and chief financial officer concluded that, as of such date, our disclosure controls and procedures were effective at the reasonable assurance level.

Changes in Internal Control Over Financial Reporting- No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the quarter ended March 31, 2006 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

PART II

OTHER INFORMATION

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

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

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

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

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

Risks Related to Being a Regulated Entity

Reduction in Medicaid, SCHIP and SSI Funding Could Substantially Reduce Our Profitability.

Most of our revenues come from Medicaid, SCHIP and SSI premiums. The base premium rate paid by each state differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix and member eligibility categories. Future levels of Medicaid, SCHIP and SSI funding and premium rates may be affected by continued government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. For example, in August 2004, the Centers for Medicare & Medicaid Services, or CMS, proposed a rule that would have required states to estimate improper payments made under their Medicaid and SCHIP programs, report such overpayments to Congress, and, if necessary, take actions to reduce erroneous payments. In October 2005, CMS announced an interim rule under which a CMS contractor will randomly select states for review once every three years to estimate each state's rate of erroneous payments, the federal share of which the states will be required to return to CMS.

In February 2006, President Bush signed into law changes in Medicaid that cut payments for prescription drugs, gave states new power to reduce or reconfigure benefits, and may lead to lower Medicaid reimbursements in some states. The Bush administration has also proposed to further reduce total federal funding for the Medicaid program by $14 billion over the next five years. Some states, including Texas, have been authorized to implement special measures to accommodate the arrival of large numbers of beneficiaries from Gulf Coast areas evacuated as a result of hurricanes Katrina and Rita, but it is unknown whether such measures will be sufficient to cover the additional Medicaid costs incurred by these states. The newly effective Medicare prescription drug benefit interrupted prescription drug coverage for many Medicaid beneficiaries, prompting several states to pay for prescription drugs on an emergency basis without any assurance of receiving full reimbursement from Medicaid.

Changes to Medicaid, SCHIP and SSI programs could reduce the number of persons enrolled or eligible, reduce the amount of reimbursement or payment levels, or increase our administrative or healthcare costs under those programs. States periodically consider reducing or reallocating the amount of money they spend for Medicaid, SCHIP and SSI. In recent years, the majority of states have implemented measures to restrict Medicaid, SCHIP and SSI costs and eligibility. Moreover, the Bush administration has proposed freezing federal spending for SCHIP at 2007 levels for ten years. We believe that reductions in Medicaid, SCHIP and SSI payments could substantially reduce our profitability. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds.

If Our Medicaid and SCHIP Contracts are Terminated or are Not Renewed, Our Business Will Suffer.

We provide managed care programs and selected services to individuals receiving benefits under federal assistance programs, including Medicaid, SSI and SCHIP. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. The contracts expire on various dates between June 30, 2006 and August 31, 2008. Our contracts may be

terminated if we fail to perform up to the standards set by state regulatory agencies. In addition, the Indiana contract under which we operate can be terminated by the State without cause. Our contracts are generally intended to run for one or two years and may be extended for one or two additional years if the state or its contractor elects to do so. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. If any of our contracts are terminated, not renewed, or renewed on less favorable terms, our business will suffer, and our operating results may be materially affected.

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

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

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

For example, Congress has considered various forms of patient protection legislation commonly known as the Patients' Bill of Rights and such legislation is frequently proposed in Congress. We cannot predict the impact of this legislation, if adopted, on our business.

Regulations May Decrease the Profitability of Our Health Plans.

Our Texas plan is required to pay a rebate to the State in the event profits exceed established levels. Similarly, our New Jersey plan is required to pay a rebate to the State in the event its health benefits ratio is less than 80%. These regulatory requirements, changes in these requirements or the adoption of similar requirements by our other regulators may limit our ability to increase our overall profits as a percentage of revenues. The states of Indiana, New Jersey and Texas have implemented prompt-payment laws and are enforcing penalty provisions for failure to pay claims in a timely manner. Failure to meet these requirements can result in financial fines and penalties. In addition, states may attempt to reduce their contract premium rates if regulators perceive our health benefits ratio as too low. Any of these regulatory actions could harm our operating results.

In recent years, CMS has reduced the rates at which states are permitted to reimburse non-state government-owned or operated hospitals for inpatient and outpatient hospital services, with the upper payment limit decreasing to 100% of Medicare payments for comparable services. Any further reductions in this limit could decrease the profitability of our health plans.

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

Federal and state governments have enacted fraud and abuse laws and other laws to protect patients' privacy and access to healthcare. Violation of these and other laws or regulations governing our operations or the operations of our providers could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide services, the suspension or revocation of our licenses or our exclusion from participating in the Medicaid, SSI and SCHIP programs. If we were to become subject to these penalties or exclusions as the result of our actions or omissions or our inability to monitor the compliance of our providers, it would

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

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

We May Incur Significant Costs as a Result of Compliance With Government Regulations, and Our Management Will Be Required to Devote Time to Compliance.

The issuance of future judicial or regulatory guidance regarding the interpretation of regulations, the states' ability to promulgate stricter rules and continuing uncertainty regarding many aspects of the regulations' implementation may make compliance with this regulatory landscape difficult. For example, our existing programs and systems may not enable us to comply in all respects with recent security regulations. In order to comply with new regulatory requirements, we were required to employ additional or different programs and systems. Further, compliance with new regulations could require additional changes to many of the procedures we currently use to conduct our business, which may lead to additional costs that we have not yet identified. We do not know whether, or the extent to which, we will be able to recover from the states our costs of complying with these new regulations. The new regulations and the related compliance costs could have a material adverse effect on our business.

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 for Medicaid, reduce the reimbursement or payment levels for medical services or reduce benefits included in Medicaid coverage. More generally, we are unable to predict whether new laws or proposals will favor or hinder the growth of managed healthcare. Legislation or regulations that require us to change our current manner of operation, 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 has 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 new 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 as part of states’ Medicaid contributions, this policy, if continued, may restrict some states’ funding for Medicaid, which could adversely affect our growth, operations and financial performance.

In February 2006, President Bush signed into law changes in Medicaid that cut payments for prescription drugs, gave states new power to reduce or reconfigure benefits, and may lead to lower Medicaid reimbursements in some sates. The Bush Administration has also proposed to further reduce total federal funding for the Medicaid program by $14 billion over the next five years. Some states, including Texas, have been authorized to implement special measures to accommodate the arrival of large numbers of beneficiaries from Gulf Coast areas evacuated as a result of hurricanes Katrina and Rita, but it is unknown whether such measures will be sufficient to cover the additional Medicaid costs incurred by these states. Any reduction or reconfiguration of state funding 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. These changes may reduce the availability of funding for some states’ Medicaid programs, which could adversely affect our growth, operations and financial performance. 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.

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 (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 our Company as a whole 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 IBNR medical expenses. We estimate our IBNR medical expenses monthly based on a number of factors. Adjustments, if necessary, are made to medical expenses in the period during which the actual claim costs are ultimately determined or when criteria used to estimate IBNR change. We cannot be sure that our IBNR estimates are adequate or that adjustments to those estimates will not harm our results of operations. From time to time in the past, our actual results have varied from our estimates, particularly in times of significant changes in the number of our members. Our failure to estimate IBNR accurately may also affect our ability to take timely corrective actions, further harming our results.

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

Nearly all of our revenues are generated by premiums consisting of fixed monthly payments per member. These premiums are fixed by contract, and we are obligated during the contract periods to provide healthcare services as established by the state governments. We use a large portion of our revenues to pay the costs of healthcare services delivered to our members. If premiums do not increase when expenses related to medical services rise, our earnings will be affected negatively. In addition, our actual medical services costs may exceed our estimates, which would cause our health benefits ratio, or our expenses related to medical services as a percentage of premium 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.

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

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

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

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

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

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

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

Accordingly, we may be unable to identify, consummate and integrate future acquisitions successfully or operate acquired businesses profitably. We also may be unable to obtain sufficient additional capital resources for future acquisitions. If we are unable to effectively execute our acquisition strategy, our future growth will suffer and our results of operations could be harmed.

If Competing Managed Care Programs are Unwilling to Purchase Specialty Services From Us, We May Not be Able to Successfully Implement Our Strategy of Diversifying Our Business Lines.

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

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

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

We Derive a Majority of Our Premium Revenues From Operations in a Small Number of States, and Our Operating Results Would be Materially Affected by a Decrease in Premium Revenues or Profitability in Any One of Those States.

Operations in Indiana, Kansas, New Jersey, Texas and Wisconsin historically have accounted for most of our premium revenues to date. If we were unable to continue to operate in each of those states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on legislative actions, economic conditions and similar factors in those states. Our inability to continue to operate in any of the states in which we operate would harm our business.

Competition May Limit Our Ability to Increase Penetration of the Markets That We Serve.

We compete for members principally on the basis of size and quality of provider network, benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state Medicaid programs that reimburse

providers as care is provided. Subject to limited exceptions by federally approved state applications, the federal government requires that there be choices for Medicaid recipients among managed care programs. Voluntary programs and mandated competition may limit our ability to increase our market share.

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

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

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

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

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

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

Loss of Providers Due to Increased Insurance Costs Could Adversely Affect Our Business.

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

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

Less favorable economic conditions may cause our membership to increase as more people become eligible to receive Medicaid benefits. During such economic downturns, however, state and federal budgets could decrease, causing states to attempt to cut healthcare programs, benefits and rates. We cannot predict the impact of changes in the United States economic environment or other economic or political events, including acts of terrorism or related military action, on federal or state funding of healthcare programs or on the size of the population eligible for the programs we operate. If federal funding decreases or remains unchanged while our membership increases, our results of operations will suffer.

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

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

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

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

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

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

Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs 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.

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

Issuer Purchases of Equity Securities (1)
First Quarter 2006

For the Month Ended	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 31, 2006	129,700	$23.76	129,700	3,870,300
February 28, 2006	—	—	—	3,870,300
March 31, 2006	—	—	—	3,870,300
TOTAL	129,700	$23.76	129,700	

(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, 2006, we did not repurchase any shares other than through this publicly announced program.

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

None.

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

None.

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

None.

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ITEM 6. ***Exhibits***

Exhibits.

EXHIBIT NUMBER	DESCRIPTION
12.1	Computation of ratio of earnings to fixed charges.
31.1	Certification of Chairman and Chief Executive Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Senior Vice President, Chief Financial Officer, Secretary and Treasurer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chairman and Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Senior Vice President, Chief Financial Officer, Secretary and Treasurer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized as of April 25, 2006.

CENTENE CORPORATION

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

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

Exhibit 12.1

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

	For the Quarter Ended 03/31/06	Year ended December 31, 2005	2004	2003	2002	2001
Earnings:						
Pre-tax earnings from continuing operations	$ 14,138	$ 85,856	$ 70,287	$ 51,893	$ 41,136	$ 22,026
Addback:						
Fixed charges	2,886	6,506	2,489	1,232	915	1,058
Total earnings	$ 17,024	$ 92,362	$ 72,776	$ 53,125	$ 42,051	$ 23,084
Fixed Charges:						
Interest expense	$ 1,998	$ 3,990	$ 680	$ 194	$ 45	$ 362
Interest component of rental payments (1)	888	2,516	1,809	1,038	870	696
Total fixed charges	$ 2,886	$ 6,506	$ 2,489	$ 1,232	$ 915	$ 1,058
Ratio of earnings to fixed charges	5.90	14.20	29.24	43.12	45.96	21.82

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

EXHIBIT 31.1

CERTIFICATION

I, Michael F. Neidorff certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Centene Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant’s other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules13a-15(e) and 15d-15(e)) and internal controls 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 25, 2006

/s/ Michael F. Neidorff

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

EXHIBIT 31.2

CERTIFICATION

I, Karey L. Witty certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Centene Corporation;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules13a-15(e) and 15d-15(e)) and internal controls 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 25, 2006

/s/ Karey L. Witty

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

EXHIBIT 32.1

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

In connection with the quarterly report on Form 10-Q of Centene Corporation (the “Company”) for the period ended March 31, 2006, as filed with the Securities and Exchange Commission on the date hereof (the “Report”), the undersigned, Michael F. Neidorff, Chairman and Chief Executive Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

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

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

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

Dated: April 25, 2006

EXHIBIT 32.2

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

In connection with the quarterly report on Form 10-Q of Centene Corporation (the "Company") for the period ended March 31, 2006, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), the undersigned, Karey L. Witty, Senior Vice President, Chief Financial Officer, Secretary and Treasurer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

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

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

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

Dated: April 25, 2006