SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

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

For the quarterly period ended September 30, 2003

OR

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

For the transition period from to

Commission file number 000-33395

CENTENE CORPORATION

(Exact name of registrant as specified in its charter)

DELAWARE	04-1406317
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification Number)
7711 CARONDELET AVENUE, SUITE 800 ST. LOUIS, MISSOURI (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: [X] Yes [ ] No

Indicate by check mark whether the registrant is an accelerated filer (as defined in Rule 12b-2 of the Act). [X] Yes [ ] No

As of October 16, 2003, the registrant had 20,063,474 shares of common stock outstanding.

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PART I

FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS
(IN THOUSANDS, EXCEPT SHARE DATA)

	SEPTEMBER 30, 2003	DECEMBER 31, 2002
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 62,906	$ 59,656
Premium and related receivables, net of allowances of $720 and $219, respectively	22,076	16,773
Short-term investments, at fair value (amortized cost $10,660 and $9,687, respectively)	10,659	9,571
Deferred income taxes	2,049	2,846
Other current assets	5,283	4,243
Total current assets	102,973	93,089
Long-term investments, at fair value (amortized cost $162,533 and $78,025, respectively)	164,685	79,666
Restricted deposits, at fair value (amortized cost $19,844 and $15,561, respectively)	20,038	15,762
Property and equipment, net	20,953	6,295
Intangible assets, net	15,232	10,695
Deferred income taxes	586	472
Other assets	3,985	4,348
Total assets	$ 328,452	$ 210,327
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liabilities	$ 91,739	$ 91,181
Accounts payable and accrued expenses	13,471	10,748
Current portion of long-term debt and notes payable	869	—
Other current liabilities	631	—
Total current liabilities	106,710	101,929
Long-term debt	7,688	—
Other liabilities	5,504	5,334
Total liabilities	119,902	107,263
Minority interest	—	881
Stockholders' equity:		
Common stock, $.001 par value; 40,000,000 shares authorized; 20,060,949 and 16,243,649 shares issued and outstanding, respectively	20	16
Additional paid-in capital	154,775	72,372
Accumulated other comprehensive income:		
Net unrealized gain on investments, net of tax	1,477	1,087
Retained earnings	52,278	28,708
Total stockholders' equity	208,550	102,183
Total liabilities and stockholders' equity	$ 328,452	$ 210,327

The accompanying notes are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES

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

	THREE MONTHS ENDED SEPTEMBER 30,		NINE MONTHS ENDED SEPTEMBER 30,	
	2003	2002	2003	2002
	(Unaudited)		(Unaudited)	
Revenues:				
Premiums	$ 195,827	$ 116,289	$ 554,939	$ 319,441
Services	2,580	109	7,134	320
Total revenues	198,407	116,398	562,073	319,761
Expenses:				
Medical costs	160,672	95,644	459,983	262,697
Cost of services	2,681	84	6,269	252
General and administrative expenses	22,414	12,642	62,698	34,804
Total operating expenses	185,767	108,370	528,950	297,753
Earnings from operations	12,640	8,028	33,123	22,008
Other income (expense):				
Investment and other income, net	1,245	6,768	3,476	8,659
Interest expense	(71)	(16)	(102)	(27)
Earnings before income taxes	13,814	14,780	36,497	30,640
Income tax expense	5,110	5,507	13,805	11,833
Minority interest	—	—	881	—
Net earnings	$ 8,704	$ 9,273	$ 23,573	$ 18,807
Earnings per common share, basic:				
Net earnings per common share	$ 0.47	$ 0.58	$ 1.38	$ 1.21
Earnings per common share, diluted:				
Net earnings per common share	$ 0.44	$ 0.52	$ 1.28	$ 1.08
Shares used in computing per share amounts:				
Basic	18,430,713	16,042,196	17,094,621	15,558,080
Diluted	19,842,145	17,750,072	18,439,050	17,348,018

The accompanying notes are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(IN THOUSANDS)

	NINE MONTHS ENDED SEPTEMBER 30,	
	2003	2002
	(Unaudited)	
Cash flows from operating activities:		
Net earnings	$ 23,573	$ 18,807
Adjustments to reconcile net earnings to net cash provided by operating activities —		
Depreciation and amortization	4,299	1,534
Stock compensation expense	232	264
Minority interest	(881)	—
Gain on sale of investments	(1,188)	(632)
Loss on disposal of equipment	102	—
Changes in assets and liabilities —		
Increase in premium and related receivables	(4,132)	(1,218)
Increase in other current assets	(849)	(663)
Decrease in deferred income taxes	452	248
Decrease in other assets	363	171
Increase in medical claims liabilities	558	5,629
Decrease in accounts payable and accrued expenses	(396)	(2,247)
Increase in unearned capitation premium	—	897
Increase in other current liabilities	27	—
Increase (decrease) in other liabilities	164	(659)
Net cash provided by operating activities	22,324	22,131
Cash flows from investing activities:		
Purchase of property and equipment	(16,253)	(3,110)
Proceeds from disposal of equipment	11	—
Purchase of investments	(291,462)	(155,690)
Sales and maturities of investments	202,306	96,975
Contract acquisitions	(1,451)	(570)
Investment in subsidiary, net of cash acquired	(1,767)	(3,193)
Net cash used in investing activities	(108,616)	(65,588)
Cash flows from financing activities:		
Net proceeds from issuance of common stock	81,403	10,317
Extinguishment of acquired liabilities	(1,218)	—
Proceeds from borrowings	8,581	—
Reduction of long-term debt	(24)	—
Cash dividends paid	(3)	—
Proceeds from exercise of stock options	803	339
Net cash provided by financing activities	89,542	10,656
Net increase (decrease) in cash and cash equivalents	3,250	(32,801)
Cash and cash equivalents, beginning of period	59,656	88,867
Cash and cash equivalents, end of period	$ 62,906	$ 56,066
Supplemental disclosures of cash flow information:		
Interest paid	$ 85	$ 11
Income taxes paid	$ 13,479	$ 11,878

The accompanying notes are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES

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

1. ORGANIZATION

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

Centene's managed care organization subsidiaries include Managed Health Services Insurance Corp. (MHSIC), a wholly owned Wisconsin corporation; Superior HealthPlan, Inc. (Superior), a wholly owned Texas corporation; Coordinated Care Corporation Indiana, Inc. (CCCI), a wholly owned Indiana corporation and University Health Plans, Inc. (UHP), a wholly owned New Jersey corporation purchased in increments in December 2002 and October 2003.

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

2. BASIS OF PRESENTATION

The unaudited interim financial statements herein have been prepared by the Company pursuant to the rules and regulations of the Securities and Exchange Commission. The accompanying interim financial statements have been prepared under the presumption that users of the interim financial information have either read or have access to the audited financial statements for the latest fiscal year ended December 31, 2002. Accordingly, footnote disclosures, which would substantially duplicate the disclosures contained in the December 31, 2002 audited financial statements, have been omitted from these interim financial statements. In the opinion of management, these financial statements reflect all adjustments, consisting only of normal recurring adjustments, which are necessary for a fair presentation of the results of the interim periods presented.

On May 27, 2003, the Company's Board of Directors declared a three-for-two stock split effected in the form of a 50% stock dividend payable July 11, 2003 to stockholders of record on June 20, 2003. All share, per share and stockholders' equity amounts have been restated to reflect this stock split.

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

The Company accounts for stock-based compensation under APB Opinion No. 25, "Accounting for Stock Issued to Employees." The Company has adopted the disclosure-only provisions of SFAS No. 123, "Accounting for Stock-Based Compensation," and SFAS No. 148, "Accounting for Stock-Based Compensation-Transition and Disclosure." The following table illustrates the effect on net income and earnings per share if the fair value based method had been applied to all awards.

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2003	2002	2003	2002
Net earnings, as reported	$ 8,704	$ 9,273	$23,573	$18,807
Pro forma stock-based employee compensation expense determined under fair value based method, net of related tax effects	400	47	1,316	182
Pro forma net earnings	$ 8,304	$ 9,226	$22,257	$18,625
Earnings per common share:				
Basic, as reported	$ 0.47	$ 0.58	$ 1.38	$ 1.21
Basic, pro forma	$ 0.45	$ 0.58	$ 1.30	$ 1.20

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2003	2002	2003	2002
Diluted, as reported	$ 0.44	$ 0.52	$ 1.28	$ 1.08
Diluted, pro forma	$ 0.42	$ 0.52	$ 1.21	$ 1.07
Shares used in computing per share amounts:				
Basic	18,430,713	16,042,196	17,094,621	15,558,080
Diluted	19,842,145	17,750,072	18,439,050	17,348,018

3. RECENTLY ISSUED ACCOUNTING PRONOUNCEMENTS

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

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

In November 2002, FIN No. 45, “Guarantor’s Accounting and Disclosure Requirements for Guarantees, Including Indirect Guarantees of Indebtedness of Others an interpretation of SFAS No. 5, 57, and 107 and rescission of FASB Interpretation No. 34,” was issued. FIN 45 clarifies the requirements of SFAS No. 5, “Accounting for Contingencies,” relating to a guarantor’s accounting for, and disclosure of, the issuance of certain types of guarantees. The adoption of FIN 45 did not have a significant impact on the net income or equity of the Company. The Company has guaranteed that one of its HMO subsidiaries shall have and maintain capital and surplus at least in the minimum amount required by law. The maximum amount of payments required under this guarantee is based on state requirements, however, the capital of this HMO exceeded the amount required at September 30, 2003. There are no recourse provisions to offset payments made under this guarantee arrangement.

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

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

In April 2003, SFAS No.149, “Amendment of Statement 133 on Derivative Instruments and Hedging Activities,” was issued. SFAS No. 149 amends and clarifies SFAS No. 133 to improve financial accounting and reporting for derivative instruments and hedging activities. To ensure that contracts with comparable characteristics are accounted for similarly, SFAS No. 149 clarifies the circumstances under which a contract with an initial net investment meets the characteristics of a derivative, clarifies when a derivative contains a financing component and amends the definition of an underlying and certain other existing pronouncements.

SFAS No. 149 is effective for contracts entered into or modified and for hedging relationships designated after September 30, 2003, except certain provisions relating to forward purchases and sales of when-issued securities or other securities that do not yet exist should be applied to both existing contracts and new contracts entered into after September 30, 2003. The adoption of SFAS No. 149 is not expected to have a material impact on the Company's financial statements.

In July 2003, SOP 03-1, "Accounting and Reporting by Insurance Enterprises for Certain Nontraditional Long-Duration Contracts and for Separate Accounts," was issued. Among other provisions, the SOP provides guidance on separate account presentation. The statement requires disclosure of the nature, extent and timing of minimum guarantees related to variable contracts and the amount of gains and losses recognized on assets transferred to separate accounts. SOP 03-1 is effective for financial statements for fiscal years beginning after December 15, 2003. The adoption of the provisions of SOP 03-1 is not expected to have a material impact on the Company's results of operations, financial position or cash flows.

4. EARNINGS PER SHARE

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2003	2002	2003	2002
Net earnings	$ 8,704	$ 9,273	$ 23,573	$ 18,807
Shares used in computing per share amounts:				
Weighted average number of common shares outstanding	18,430,713	16,042,196	17,094,621	15,558,080
Common stock equivalents (as determined by applying the treasury stock method)	1,411,432	1,707,876	1,344,429	1,789,938
Weighted average number of common shares and potential dilutive common shares outstanding	19,842,145	17,750,072	18,439,050	17,348,018
Earnings per common share, basic:				
Net earnings per common share	$ 0.47	$ 0.58	$ 1.38	$ 1.21
Earnings per common share, diluted:				
Net earnings per common share	$ 0.44	$ 0.52	$ 1.28	$ 1.08

5. ACQUISITION OF GROUP PRACTICE AFFILIATES

Effective March 1, 2003, Cenphiny, a wholly owned subsidiary of Centene, acquired a 63.7% ownership interest in Group Practice Affiliates, LLC (GPA). GPA, a behavioral healthcare services company, serves over 700,000 individuals in four states through a combination of networks, groups and schools including a portion of Centene's membership. Effective August 15, 2003, Cenphiny acquired the remaining 36.3% and now owns 100% of GPA. The consolidated financial statements include the results of operations of GPA since March 1, 2003.

Cenphiny paid approximately $5,082 for its total investment in GPA. The cost to acquire the ownership interest has been preliminarily allocated to the assets acquired and liabilities assumed according to estimated fair values and is subject to adjustment when additional information concerning asset and liability valuations are finalized. The preliminary allocation has resulted in goodwill of approximately $3,786. The goodwill is not amortized and is not deductible for tax purposes.

In connection with the acquisition of the remaining 36.3% of GPA, Centene made the decision to close the Atlanta, Georgia office and transition the overhead functions provided to the Company's other offices. This closure will result in a reduction of employment of approximately 26 people. The estimated cost of this action, $377, was accrued in the opening balance sheet. At September 30, 2003, the Company has terminated one employee in connection with this closure. The remaining accrual for severance, $200, is expected to be paid in the fourth quarter of 2003.

6. CONTRACT ACQUISITIONS

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

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

Effective August 1, 2003, Superior HealthPlan, Inc. (Superior), a wholly owned Texas corporation, acquired the Medicaid-related contract rights of HMO Blue Texas in the San Antonio, Texas market. This transaction allows Superior to serve approximately 17,000 additional members in the state.

Superior paid approximately $890 in cash in connection with the purchase. Superior allocated the entire purchase price of $890 to identifiable intangible assets, representing the value assigned to acquired contracts, which is being amortized on a straight-line basis over a period of five years, the expected period of benefit.

7. LONG TERM DEBT AND NOTES PAYABLE

In August 2003, the Company borrowed $8,000 under a non-recourse mortgage loan arrangement to finance a portion of its corporate headquarters building purchase price. The mortgage bears interest at the prevailing prime rate less ..25%. At September 30, 2003 the mortgage bore interest at 3.75%. Maturities on the mortgage are as follows:

October 1 through December 31, 2003	$ 72
2004	288
2005	288
2006	288
2007	288
2008	6,752
Total	$7,976

Additionally, in August 2003, the Company issued a $581 promissory note payable as part of the acquisition of the remaining 36.3% of GPA.

8. SUBSEQUENT EVENTS

In September 2003, the Company signed a definitive agreement to acquire the Medicaid-related assets of Family Health Plan, Inc., a wholly owned subsidiary of Mercy Health Partners. This transaction includes the right to serve up to 24,000 of Family Health Plan's Medicaid members in Toledo, Ohio, a new market for the Company. The purchase price is approximately $6.5 million. The Company anticipates this acquisition to be effective in the first quarter of 2004. This acquisition, if completed, will be accounted for under the purchase method of accounting.

On October 15, 2003, the Company exercised its option to purchase the remaining 20% of UHP for approximately $2.6 million.

On October 16, 2003, the Company began trading of its common stock on the New York Stock Exchange. The Company's common stock was previously traded on the NASDAQ.

9. SEGMENT INFORMATION

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

With the acquisition of GPA and the purchase of ScriptAssist assets on March 1, 2003, Centene began operating in two segments: Medicaid Managed Care and Specialty Services. The Medicaid Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene's specialty companies including behavioral health, nurse triage and pharmacy compliance functions.

Segment information for the nine months ended September 30, 2003, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 555,044	$ 7,029	$ —	$ 562,073
Revenue from internal customers	10,848	7,948	(18,796)	—
Total revenue	$ 565,892	$14,977	$ (18,796)	$ 562,073
Net earnings	$ 21,958	$ 1,615	$ —	$ 23,573
Total assets	$ 322,771	$ 5,681	$ —	$ 328,452

Segment information for the three months ended September 30, 2003, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 195,848	$2,559	$ —	$ 198,407
Revenue from internal customers	7,304	4,111	(11,415)	—
Total revenue	$ 203,152	$6,670	$ (11,415)	$ 198,407
Net earnings	$ 8,497	$ 207	$ —	$ 8,704

The Company evaluates performance and allocates resources based on net earnings. The accounting policies are the same as those described in the "Summary of Significant Accounting Policies" included in Note 2 of the annual consolidated financial statements. Revenue from internal customers is eliminated in consolidation.

10. COMPREHENSIVE INCOME

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2003	2002	2003	2002
Net earnings	$ 8,704	$ 9,273	$23,573	$18,807
Reclassification adjustment, net of tax	(198)	(72)	(474)	(116)
Unrealized gains on investments available for sale, net of tax	471	778	864	912
Total comprehensive income	$ 8,977	$ 9,979	$23,963	$19,603

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

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes appearing elsewhere in this report and in our annual report on Form 10-K for the year ended December 31, 2002. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth below under "Factors that May Affect Future Results and the Trading Price of Our Common Stock."

OVERVIEW

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

Effective August 1, 2003, we acquired the Medicaid-related contract rights of HMO Blue Texas in the San Antonio, Texas market. This transaction allows us to serve approximately 17,000 additional members in the state. We paid approximately $890,000 in cash in connection with the purchase. We allocated the entire purchase price to identifiable intangible assets, representing the value assigned to acquired contracts, which is being amortized on a straight-line basis over a period of five years, the expected period of benefit.

Effective March 1, 2003, we acquired a 63.7% ownership interest in Group Practice Affiliates, or GPA. GPA, a behavioral healthcare services company, serves over 700,000 individuals in four states through a combination of networks, groups and schools, including a portion of our membership. Effective August 15, 2003, we acquired the remaining 36.3%. This acquisition is consistent with our strategy to provide diversified medical services to the managed Medicaid population. We paid $5.1 million for our total investment in GPA. The preliminary allocation of acquired assets and liabilities has resulted in goodwill of $3.8 million.

Also effective March 1, 2003, we purchased contract and name rights of ScriptAssist, a medication compliance company, for $561,000 in cash. We are administering the purchased contracts under the ScriptAssist name. ScriptAssist uses various approaches and medical expertise to promote adherence to prescription drugs. The asset acquisition is consistent with our strategy to provide diversified medical services to the managed Medicaid population. As a result of the ScriptAssist transaction, $561,000 was allocated to an intangible asset, purchased contract rights. We are amortizing the contract rights on a straight-line basis over five years, the period expected to be benefited.

On December 1, 2002, we acquired 80% of the outstanding capital stock of University Health Plans, or UHP, from University of Medicine and Dentistry of New Jersey, or UMDNJ. UHP is a managed health plan operating in 20 counties in New Jersey. We paid an aggregate purchase price of $10.6 million for our initial interest in UHP. On October 15, 2003 we exercised our option to purchase the remaining 20% of UHP for $2.6 million.

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

With our acquisition of GPA and our purchase of ScriptAssist assets, we began operating in two segments: Medicaid Managed Care and Specialty Services. The Medicaid Managed Care segment consists of our health plans, including all of the functions needed to operate them. The Specialty Services segment consists of our specialty companies, including our behavioral health, nurse triage and pharmacy compliance functions.

REVENUES

We generate revenues primarily from premiums we receive from the states in which we operate to provide health benefits to our members. We receive a fixed premium per member per month pursuant to our state contracts. We generally receive premiums during the month we provide services and recognize premium revenue during the period in which we are obligated to provide services to our

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

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

The primary driver of our increasing revenues has been membership growth. We have increased our membership through internal growth and acquisitions. From September 30, 2002 to September 30, 2003, we increased our membership by 58%. The following table sets forth our membership by state:

	September 30,	
	2003	2002
Wisconsin	150,200	126,800
Texas	152,100	67,800
Indiana	112,100	101,500
New Jersey	52,700	—
Total	467,100	296,100

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

	September 30,	
	2003	2002
Medicaid (excluding SSI)	389,200	264,100
SCHIP	68,600	29,400
SSI	9,300	2,600
Total	467,100	296,100

Our membership increased by 41,000 members in Texas due to the purchase of Medicaid-related contract rights from HMO Blue Texas in the third quarter of 2003 and SCHIP contract rights from Texas Universities Health Plan in the third and fourth quarters of 2002. In addition, two competing plans exited the Austin, Texas market during 2002. As a result, our Texas plan increased its membership by an additional 28,000 lives in 2002. This increase includes 12,000 lives that we are managing for the state of Texas on an interim basis and that will become part of a re-procurement process scheduled for mid-2004. We entered the New Jersey market through our acquisition of UHP in December 2002. The remaining membership increases in our Wisconsin, Texas and Indiana markets resulted from additions to our provider network and growth in the number of Medicaid beneficiaries.

OPERATING EXPENSES

Our operating expenses include medical costs, cost of services, and general and administrative expenses.

Our medical costs include payments to physicians, hospitals, and other providers for healthcare and specialty product claims. Medical costs also include estimates of medical expenses incurred but not yet reported, or IBNR. Monthly, we estimate our IBNR based on a number of factors, including inpatient hospital utilization data and prior claims experience. As part of this review, we also consider the costs to process medical claims, and estimates of amounts to cover uncertainties related to fluctuations in physician billing patterns, membership, products and inpatient hospital trends. These estimates are adjusted as more information becomes available. We utilize the services of independent actuarial consultants who are contracted to review our estimates quarterly. While we believe that our process for estimating IBNR is actuarially sound, we cannot assure you that healthcare claims costs will not materially differ from our estimates.

Our results of operations depend on our ability to manage expenses related to health benefits and to accurately predict costs incurred. Our health benefits ratio represents medical costs as a percentage of premium revenues and reflects the direct relationship between the premium received and the medical services provided. The table below depicts our health benefits ratios by member category and in total:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2003	2002	2003	2002
Medicaid (excluding SSI) and SCHIP	81.3%	82.2%	82.0%	82.2%
SSI	102.9	—	103.5	—
Total	82.0	82.2	82.9	82.2

While our core Medicaid business remained consistent between periods, the addition of the SSI members in New Jersey in December 2002 has caused our heath benefits ratio for the nine months ended September 30, 2003 to increase. The health benefits ratio for SSI is affected by a low membership base, which subjects us to volatility. We expect the health benefits ratio for SSI to decrease as these members become fully integrated into our medical management programs, as our membership base grows within the state of New Jersey and as our membership base grows in other markets.

Our cost of services expenses include all direct costs to support the local functions responsible for generation of our services revenues. These expenses primarily consist of the salaries and wages of the physicians, clinicians, therapists and teachers who provide the services and expenses related to the clinics and supporting facilities and equipment used to provide services.

Our general and administrative expenses primarily reflect wages and benefits and other administrative costs related to health plans and our centralized functions that support all of our business units. The major centralized functions are claims processing, information systems, finance, medical management support, provider contracting support, human resources and administration. Our general and administrative expenses ratio represents general and administrative expenses as a percentage of total revenues and reflects the relationship between revenues earned and the costs necessary to drive those revenues. The following table sets forth the general and administrative expenses ratios by business segment and in total:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2003	2002	2003	2002
Medicaid Managed Care	10.1%	10.9%	10.3%	10.9%
Specialty Services	32.0	—	31.0	—
Total	11.3	10.9	11.2	10.9

OTHER INCOME (EXPENSE)

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

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

- Interest expense primarily reflects mortgage interest on our corporate headquarters building and non-use fees paid to a bank in conjunction with our revolving credit facility.

RESULTS OF OPERATIONS

NINE MONTHS ENDED SEPTEMBER 30, 2003 COMPARED TO NINE MONTHS ENDED SEPTEMBER 30, 2002

Revenues

Premiums for the nine months ended September 30, 2003 increased $235.5 million, or 73.7%, to $554.9 million from $319.4

million for the comparable period in 2002. This increase was due to organic growth in our existing markets, changes in our member mix by product category, the purchase of the Texas contracts and the addition of our New Jersey membership through our acquisition of UHP. In addition, we received weighted average rate increases effective January 1, 2003 of 1.0% in Indiana and 4.3% in Wisconsin; effective July 1, 2003 of 6.2% in New Jersey; and effective September 1, 2003 of 7.5% in Texas.

Services revenues for the nine months ended September 30, 2003 increased $6.8 million to $7.1 million from $320,000 for the comparable period in 2002. This increase resulted from the addition of GPA services revenues since March 1, 2003 and increases in our non-risk SSI membership in our Texas market.

Operating Expenses

Medical costs for the nine months ended September 30, 2003 increased $197.3 million, or 75.1%, to $460.0 million from $262.7 million for the comparable period in 2002. This increase primarily reflected the growth in our membership as described above.

Cost of services for the nine months ended September 30, 2003 increased $6.0 million to $6.3 million from $252,000 for the comparable period in 2002. This increase was due primarily to the inclusion of direct costs related to the services revenues of GPA since March 1, 2003.

General and administrative expenses for the nine months ended September 30, 2003 increased $27.9 million, or 80.1%, to $62.7 million from $34.8 million for the comparable period in 2002. This increase reflected a higher level of wages and related expenses for additional staff to support our membership growth and expanding markets. In addition, facilities charges and related expenses have increased to support our increased membership.

Other Income (Expense)

Other income (expense) for the nine months ended September 30, 2003 decreased $5.3 million, or 60.9%, to $3.4 million from $8.6 million for the comparable period in 2002. Our 2002 results of operations included a one-time dividend of $5.1 million from a captive insurance company in which we maintained an investment. Excluding this one-time gain, other income was essentially flat with higher investment balances in 2003 offset by a lower interest rate environment.

Income Tax Expense

For the nine months ended September 30, 2003, we recorded income tax expense of $13.8 million based on a 37.8% effective tax rate. For the nine months ended September 30, 2002, we recorded income tax expense of $11.8 million based on an effective tax rate of 38.6%. Our effective tax rate decreased period over period due to our utilization of net operating loss carryforwards obtained with certain of our acquisitions.

THREE MONTHS ENDED SEPTEMBER 30, 2003 COMPARED TO THREE MONTHS ENDED SEPTEMBER 30, 2002

Revenues

Premiums for the three months ended September 30, 2003 increased $79.5 million, or 68.4%, to $195.8 million from $116.3 million for the comparable period in 2002. This increase was due to organic growth in our existing markets, changes in our member mix by product category, the purchase of the Texas contracts and the addition of our New Jersey membership through our acquisition of UHP. In addition, we received weighted average rate increases effective January 1, 2003, of 1.0% in Indiana and 4.3% in Wisconsin; effective July 1, 2003 of 6.2% in New Jersey; and effective September 1, 2003 of 7.5% in Texas.

Services revenues for the three months ended September 30, 2003 increased $2.5 million to $2.6 million from $109,000 for the comparable period in 2002. This increase resulted from the addition of GPA services revenues which we acquired March 1, 2003 and increases in our non-risk SSI membership in our Texas market.

Operating Expenses

Medical costs for the three months ended September 30, 2003 increased $65.0 million, or 68.0%, to $160.7 million from $95.6 million for the comparable period in 2002. This increase primarily reflected the growth in our membership as described above.

Medical costs as a percentage of premium revenue were lower in the three months ended September 30, 2003 partially due to a distribution from an escrow account for costs incurred prior to our acquisition of UHP.

Cost of services for the three months ended September 30, 2003 increased $2.6 million to $2.7 million from $84,000 for the comparable period in 2002. This increase was due primarily to the inclusion of direct costs related to the services revenue of GPA.

General and administrative expenses for the three months ended September 30, 2003 increased $9.8 million, or 77.3%, to $22.4 million from $12.6 million for the comparable period in 2002. This increase reflected a higher level of wages and related expenses for additional staff to support our membership growth and expanding markets. In addition, facilities charges and related expenses have increased to support our increased membership.

Other Income (Expense)

Other income (expense) for the three months ended September 30, 2003 decreased $5.6 million, or 82.6%, to $1.2 million from $6.8 million for the comparable period in 2002. Our 2002 results of operations included a one-time dividend of $5.1 million from a captive insurance company in which we maintained an investment. Excluding this one-time gain, other income decreased $500,000 with a lower interest rate environment partially offset by higher investment balances in 2003.

Income Tax Expense

For the three months ended September 30, 2003, we recorded income tax expense of $5.1 million based on a 37.0% effective tax rate. For the three months ended September 30, 2002, we recorded income tax expense of $5.5 million based on an effective tax rate of 37.3%. Our effective tax rate decreased period over period due to our utilization of net operating loss carryforwards obtained with certain of our acquisitions.

LIQUIDITY AND CAPITAL RESOURCES

On August 13, 2003, we closed our follow-on public offering of 3,450,000 shares of common stock, including the underwriters over-allotment option, exercised on August 11, 2003, at $25.00 per share. We received net proceeds totaling $81.4 million from the follow-on offering. We intend to use our net proceeds for working capital and other general corporate purposes, which may include acquisitions of businesses, assets and technologies that are complementary to our business. We may use proceeds to acquire Medicaid and SCHIP businesses, specialty services businesses and contract rights in order to increase our membership and to expand our business into new service areas.

Our operating activities provided cash of $22.3 million for the nine months ended September 30, 2003 compared to $22.1 million for the nine months ended September 30, 2002. This slight increase was due to continued profitability and an increase in membership, offset by an increase in premium and related receivables.

Our investing activities used cash of $108.6 million for the nine months ended September 30, 2003 and $65.6 million for the comparable period in 2002. Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets within our investment guidelines. Net cash provided by and used in investing activities will fluctuate from year to year due to the timing of investment purchases, sales and maturities. As of September 30, 2003, our investment portfolio consisted primarily of fixed-income securities with an average duration of 3.2 years. Cash is invested in investment vehicles such as municipal bonds, commercial paper, and instruments of U.S. government-backed agencies and the U.S. Treasury. The states in which we operate prescribe the types of instruments in which our subsidiaries may invest their cash. The average annualized portfolio yield was 4.5% for the nine months ended September 30, 2003 and 6.9% for the year ended December 31, 2002 (exclusive of a one-time dividend of $5.1 million from a captive insurance company in which we maintained an investment). Our yield decreased due to a decrease in the overall interest rate environment.

Our financing activities provided cash of $89.5 million for the nine months ended September 30, 2003 and $10.7 million for the nine months ended September 30, 2002. Cash provided by financing activities for the nine months ended September 30, 2003 was primarily due to the proceeds from the issuance of common stock through our follow-on public offering completed in August 2003. Cash provided by financing activities for the nine months ended September 30, 2002 was primarily due to the proceeds from the issuance of common stock through a follow-on public offering completed in May 2002.

Our capital expenditures consist primarily of new software, software and hardware upgrades, and furniture, equipment and

leasehold improvements related to office and market expansions. We purchased $3.7 million of capital assets during the nine months ended September 30, 2003, and we anticipate spending $3.0 million for additional capital expenditures during the remainder of 2003 on office and market expansions, system upgrades, facilities renovations and a mail distribution center.

In July 2003, we purchased the building in which our corporate headquarters in Saint Louis, Missouri are located for an aggregate purchase price of $12.6 million. We financed a portion of the purchase price through an $8.0 million non-recourse mortgage loan arrangement. The mortgage bears interest at the prevailing prime rate less .25%. At September 30, 2003, our mortgage bore interest at 3.75%.

Our principal contractual obligations at September 30, 2003 consisted of obligations under operating leases and mortgage obligations for our corporate headquarters purchase. The significant non-cancelable lease and mortgage payments over the next five years and beyond are as follows (in thousands):

	Payments Due
October 1 through December 31, 2003	$ 1,361
2004	5,150
2005	4,638
2006	4,041
2007	3,447
Thereafter	12,139
Total	$ 30,776

Effective May 1, 2003, we extended our $25 million revolving line of credit facility with LaSalle Bank N.A. until May 2004. The facility has an interest rate based on LaSalle's prime rate or LIBOR. In order to secure our obligations under the facility, we have granted a security interest in the common stock of our subsidiaries. The facility includes financial covenants, including requirements of minimum EBITDA and minimum tangible net worth. We are required to obtain LaSalle's consent to proposed acquisitions that would result in a violation of any of the covenants contained in the facility. As of September 30, 2003, we were in compliance with all covenants and no funds were outstanding on the facility.

At September 30, 2003, we had working capital, defined as current assets less current liabilities, of $(3.7) million as compared to $(8.8) million at December 31, 2002. Our working capital is often minimal and sometimes negative due to our efforts to increase investment returns through purchases of investments that have maturities of greater than one year and, therefore, are classified as long-term. Our investment policies are also designed to provide liquidity and preserve capital. We manage our short-term and long-term investments to ensure that a sufficient portion is held in investments that are highly liquid and can be sold to fund working capital as needed.

Cash, cash equivalents and short-term investments were $73.6 million at September 30, 2003 and $69.2 million at December 31, 2002. Long-term investments were $184.7 million at September 30, 2003 and $95.4 million at December 31, 2002, including restricted deposits of $20.0 million at September 30, 2003 and $15.8 million at December 31, 2002. Cash and investments held by our unregulated entities totaled $132.5 million at September 30, 2003. Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our credit facility will be sufficient to finance our operations and capital expenditures for at least 12 months from the date of this report.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

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

Our subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of September 30, 2003, our subsidiaries had aggregate statutory capital and surplus of $49.9 million,

compared with the required minimum aggregate statutory capital and surplus requirements of $27.1 million.

The National Association of Insurance Commissioners adopted guidelines which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. Wisconsin and Texas adopted various forms of the rules as of December 31, 1999. As of December 31, 2002, our Wisconsin and Texas health plans were in compliance with risk-based capital requirements. Indiana has adopted risk-based capital rules that will take effect as of December 31, 2004. The managed care organization rules, if adopted by New Jersey, may increase the minimum capital required for our health plan in New Jersey. We continue to monitor these requirements in Indiana and New Jersey and do not expect that they will have a material impact on our results of operations, financial position or cash flows.

RECENT ACCOUNTING PRONOUNCEMENTS

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

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

In November 2002, FIN No. 45, "Guarantor's Accounting and Disclosure Requirements for Guarantees, Including Indirect Guarantees of Indebtedness of Others an interpretation of SFAS No. 5, 57, and 107 and rescission of FASB Interpretation No. 34," was issued. FIN 45 clarifies the requirements of SFAS No. 5, "Accounting for Contingencies," relating to a guarantor's accounting for, and disclosure of, the issuance of certain types of guarantees. The adoption of FIN 45 did not have a significant impact on our net income or equity. We have guaranteed that one of our HMO subsidiaries shall have and maintain capital and surplus at least in the minimum amount required by law. The maximum amount of payments required under this guarantee is based on state requirements, however, the capital of this HMO exceeded the amount required at September 30, 2003. There are no recourse provisions to offset payments made under this guarantee arrangement.

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

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

In April 2003, SFAS No.149, "Amendment of Statement 133 on Derivative Instruments and Hedging Activities," was issued.

SFAS No. 149 amends and clarifies SFAS No. 133 to improve financial accounting and reporting for derivative instruments and hedging activities. To ensure that contracts with comparable characteristics are accounted for similarly, SFAS No. 149 clarifies the circumstances under which a contract with an initial net investment meets the characteristics of a derivative, clarifies when a derivative contains a financing component and amends the definition of an underlying and certain other existing pronouncements. SFAS No. 149 is effective for contracts entered into or modified and for hedging relationships designated after September 30, 2003, except certain provisions relating to forward purchases and sales of when-issued securities or other securities that do not yet exist should be applied to both existing contracts and new contracts entered into after September 30, 2003. We do not expect that adoption of SFAS No. 149 will have a material impact on our financial statements.

In July 2003, SOP 03-1, "Accounting and Reporting by Insurance Enterprises for Certain Nontraditional Long-Duration Contracts and for Separate Accounts," was issued. Among other provisions, the SOP provides guidance on separate account presentation. The statement requires disclosure of the nature, extent and timing of minimum guarantees related to variable contracts and the amount of gains and losses recognized on assets transferred to separate accounts. SOP 03-1 is effective for financial statements for fiscal years beginning after December 15, 2003. The adoption of the provisions of SOP 03-1 is not expected to have a material impact on our results of operations, financial position or cash flows.

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

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

RISKS RELATED TO BEING A REGULATED ENTITY

Reductions in Medicaid and SCHIP Funding Could Substantially Reduce Our Profitability.

Nearly all of our revenues come from Medicaid and SCHIP 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 and SCHIP premium rates may be affected by continued government efforts to contain medical costs and may further be affected by state and federal budgetary constraints. Changes to Medicaid and SCHIP 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 and SCHIP. We believe that reductions in Medicaid and SCHIP 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 December 31, 2003 and August 31, 2004. Our contracts with the states of Indiana and Wisconsin accounted for 73% of our revenues for the year ended December 31, 2002. Our contracts may be terminated if we fail to perform up to the standards set by state regulatory agencies. In addition, the Indiana contract under which we operate can be terminated by the state without cause. Our contracts are generally intended to run for two years and may be extended for one or two additional years if the state or its contractor elects to do so. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. If any of our contracts are terminated, not renewed, or renewed on less favorable terms, our business will suffer, and our operating results may be materially affected.

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

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

and rules could, among other things:

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

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

Regulations May Decrease the Profitability of Our Health Plans.

Our Texas plans are required to pay a rebate to the state in the event profits exceed established levels. Similarly, our New Jersey plans are required to pay a rebate to the state in the event their 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 Texas, Indiana and New Jersey 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.

Also, on January 18, 2002, the federal Centers for Medicare and Medicaid Services, or CMS, published a final rule that removed a provision contained in the federal Medicaid reimbursement regulations permitting states to reimburse non-state government-owned or operated hospitals for inpatient and outpatient hospital services at amounts up to 150 percent of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicaid payment principles. The upper payment limit was reduced to 100% of Medicare payments for comparable services. This development in federal regulation decreased 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 impact our ability to operate our business. For example, failure to pay our providers promptly could result in the imposition of fines and other penalties. In some states, we may be subject to regulation by more than one governmental authority, which may impose overlapping or inconsistent regulations.

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

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

On August 17, 2000, the United States Department of Health and Human Services, or HHS, issued a new regulation under HIPAA requiring the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. We have been required to comply with this regulation since October 16, 2003. In December 2000, HHS issued a new regulation mandating heightened privacy and confidentiality protections under HIPAA that became effective on April 14, 2001 and for which compliance was required by April 14, 2003. We are taking steps to integrate the privacy policies and procedures of GPA, which we acquired in March 2003, with the privacy policies and procedures we have implemented in our other operations. On February 20, 2003 HHS published the final HIPAA health data security regulations. The security regulations became effective on April 21, 2003. Compliance with the security regulations is required by April 21, 2005. These regulations will require covered entities to implement administrative, physical and technical safeguards to protect electronic health information maintained or transmitted by the organization.

The 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 the relatively new regulatory landscape difficult. For example, our existing programs and systems may not enable us to comply in all respects with the new security regulations. In order to comply with the regulatory requirements, we will be required to employ additional or different programs and systems, the costs of which are not expected to exceed $500,000 in 2003. Further, compliance with these regulations would require changes to many of the procedures we currently use to conduct our business, which may lead to additional costs that we have not yet identified. We do not know whether, or the extent to which, we will be able to recover 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.

Changes in Federal Funding Mechanisms May Reduce Our Profitability.

In February 2003, the Bush Administration proposed a major long-term change in the way Medicaid and SCHIP are funded. The proposal, if adopted, would allow states to elect to receive combined Medicaid-SCHIP "allotments" for acute and long-term health care for low-income, uninsured persons. Participating states would be given flexibility in designing their own health insurance programs, subject to federally-mandated minimum coverage requirements. It is uncertain whether this proposal will be enacted, or if so, how it may change from the initial proposal. Accordingly, it is unknown whether or how many states might elect to participate or how their participation may affect the net amount of funding available for Medicaid and SCHIP programs. If such a proposal is adopted and decreases the number of persons enrolled in Medicaid or SCHIP in the states in which we operate or reduces the volume of healthcare services provided, our growth, operations and financial performance could be adversely affected.

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

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

If State Regulators Do Not Approve Payments of Dividends and Distributions by Our Subsidiaries to Us, We May Not Have Sufficient Funds to Implement Our Business Strategy.

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

RISKS RELATED TO OUR BUSINESS

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

Nearly all of our revenues are generated by premiums consisting of fixed monthly payments per member. These premiums are

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

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

Our profitability depends, to a significant degree, on our ability to predict and effectively manage expenses related to health benefits. We have less control over the costs related to medical services than we do over our general and administrative expenses. Historically, our health benefits ratio has fluctuated. For example, our health benefits ratio was 82.9% for the nine months ended September 30, 2003, 82.3% for 2002, 82.8% for 2001 and 84.3% for 2000, but was 88.9% for 1999 and 88.4% for 1998. Because of the narrow margins of our health plan business, relatively small changes in our health benefits ratio can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of use of healthcare services, hospital costs, pharmaceutical costs, major epidemics, new medical technologies and other external factors, including general economic conditions such as inflation levels, are beyond our control and could reduce our ability to predict and effectively control the costs of providing health benefits. We may not be able to manage costs effectively in the future. If our costs related to health benefits increase, our profits could be reduced or we may not remain profitable.

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

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

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

Historically, the acquisition of Medicaid businesses, contract rights and related assets of other health plans both in our existing service areas and in new markets has accounted for a significant amount of our growth. For example, our acquisition of 80% of the equity of University Health Plans, or UHP, on December 1, 2002, accounted for 30.3% of the increase in our membership for the year ended December 31, 2002 compared to 2001. Many of the other potential purchasers of Medicaid assets have greater financial resources than we have. In addition, many of the sellers are interested either in (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. Furthermore, our credit facility may prohibit some acquisitions without the consent of our bank lender.

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

- additional personnel who are not familiar with our operations and corporate culture;
- existing provider networks, which may operate on different terms than our existing networks;

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

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

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

If Competing Medicaid Managed Care Programs are Unwilling to Purchase Specialty Services From Us, We May Be Unable 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. Effective March 1, 2003, for example, we acquired a 63.7% interest in GPA, a behavioral health services company, and purchased contract and name rights of ScriptAssist, a medication compliance company. In order to diversify our business, we must succeed in selling the services of GPA, ScriptAssist and any other 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 Medicaid 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. In addition, we may not be able to effectively commercialize any new programs or services we seek to market to third-parties. The expenses associated with starting up a new business could have a significant impact on our results of operations if we are unable to achieve profitable operations in a timely fashion.

We Derive a Majority of Our Premium Revenues from Operations in Four 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 Wisconsin, Texas, Indiana and New Jersey account for all of our premium revenues. If we were unable to continue to operate in each of those states or if our current operations in any portion of one of those states were significantly curtailed, our revenues would decrease materially. For example, in the first half of 2001, our membership in Indiana declined by approximately 46,000 due to a subcontracting provider organization terminating a percent-of-premium arrangement. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly, depending on legislative actions, economic conditions and similar factors in those states. Our inability to continue to operate in any of the states in which we operate would harm our business.

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

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

Some of the health plans with which we compete have greater financial and other resources and offer a broader scope of products than we do. In addition, significant merger and acquisition activity has occurred in the managed care industry, as well as in industries that act as suppliers to us, such as the hospital, physician, pharmaceutical, medical device and health information systems 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 Satisfactory Relationships with Our Provider Networks, Our Profitability Will Be Harmed.

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

From time to time providers assert or threaten to assert claims seeking to terminate noncancelable agreements due to alleged actions or inactions by us. Even if these allegations represent attempts to avoid or renegotiate contractual terms that have become economically disadvantageous to the providers, it is possible that in the future a provider may pursue such a claim successfully. 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 Medicaid managed care business. If we lose one or more members of our senior management team, including our chief executive officer, Michael F. Neidorff, who has been instrumental in developing our mission and forging our business relationships, our business and operating results could be harmed. We do not have an employment agreement with Mr. Neidorff, and we cannot assure you that we will be able to retain his services. Our ability to replace any departed members of our senior management or other key employees may be difficult and may take an extended period of time because of the limited number of individuals in the Medicaid managed care industry with the breadth of skills and experience required to operate and expand successfully a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel.

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

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

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

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

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

Less favorable economic conditions may cause our membership to increase as more people become eligible to receive Medicaid benefits. During such economic downturns, however, state and federal budgets could decrease, causing states to attempt to cut healthcare programs, benefits and rates. 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 Primarily into Markets Where Medicaid Recipients Are Required to Enroll in Managed Care Plans.

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

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

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

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

We May Not Be Able to Obtain and Maintain Adequate Insurance.

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

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK.

INVESTMENTS

As of September 30, 2003, we had short-term investments of $10.7 million and long-term investments of $184.7 million, including restricted deposits of $20.0 million. The short-term investments consisted of highly liquid securities with maturities between three and twelve months. The long-term investments consisted of municipal bonds and instruments of U.S. government-backed agencies and the U.S. Treasury, and had original maturities greater than one year. Restricted deposits consisted of investments required by various state

statutes to be deposited or pledged to state agencies. These investments are classified as long-term regardless of the contractual maturity date due to the nature of the states' requirements. These investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold the short-term investments to maturity, and as a result, we would not expect the value of these investments to decline significantly as a result of a sudden change in market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at September 30, 2003, the fair value of our fixed income investments would have decreased by $5.7 million. Similarly, a 1% decrease in market interest rates at September 30, 2003 would have resulted in an increase of the fair value of our investments of $5.7 million. Declines in interest rates over time will reduce our investment income.

INFLATION

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

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

COMPLIANCE COSTS

Federal and state regulations governing standards for electronic transactions, data security and confidentiality of patient information have been issued recently. Due to the uncertainty surrounding the regulatory requirements, we cannot be sure that the systems and programs that we have implemented will comply adequately with the security regulations that are ultimately adopted. Implementation of additional systems and programs will be required, the cost of which we estimate not to exceed $500,000 in 2003. We incurred implementation costs of $268,000 in the nine months ended September 30, 2003. Further, compliance with these regulations would require changes to many of the procedures we currently use to conduct our business, which may lead to additional costs that we have not yet identified. We do not know whether, or the extent to which, we will be able to recover our costs of complying with these new regulations from the states.

ITEM 4. CONTROLS AND PROCEDURES.

Our management, with the participation of our chief executive officer and chief financial officer, evaluated the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act) as of September 30, 2003. Based on this evaluation, our chief executive officer and chief financial officer concluded that, as of September 30, 2003, our disclosure controls and procedures were (1) designed to ensure that material information relating to us, and our consolidated subsidiaries, is made known to our chief executive officer and chief financial officer by others within those entities, particularly during the period in which this report was being prepared, and (2) effective, in that they provide reasonable assurance that information required to be disclosed by us in the reports that we file or submit under the Exchange Act are recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms.

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 fiscal quarter ended September 30, 2003 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.

Aurora Health Care, Inc., or Aurora, provides medical professional services to our Wisconsin health plan subsidiary, Managed Health Services, or MHS. In May 2003 Aurora filed a lawsuit against MHS in the Milwaukee County Circuit Court disputing MHS's interpretation of its contract with Aurora and claiming that, as a result of such interpretation, MHS had failed to adequately reimburse Aurora for services rendered to MHS's Medicaid members during the period from 1998 to 2003. The claim seeks damages totaling $7.9 million. MHS disputes the claim, has filed an answer and discovery requests against Aurora, and plans to vigorously defend against the matter. While the case is in the early stages of litigation, we do not expect the matter will have a material effect on our business or financial position.

In addition, we may become subject to legal proceedings in the normal course of our business. We are not currently subject to any legal proceedings that will materially affect our business or results of operations.

ITEM 2. CHANGES IN SECURITIES AND USE OF PROCEEDS.

None.

ITEM 3. DEFAULTS UPON SENIOR SECURITIES.

None.

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

None.

ITEM 5. OTHER INFORMATION.

None.

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

(a) Exhibits.

EXHIBIT NUMBER	DESCRIPTION
10.1	Second Amendment, dated as of August 1, 2003, to Loan Agreement by and between LaSalle Bank National Association and Centene Corporation.
31.1	Certification of President and Chief Executive Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Senior Vice President, Chief Financial Officer and Treasurer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of President and Chief Executive Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Senior Vice President, Chief Financial Officer and Treasurer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

(b) Reports on Form 8-K.

On July 29, 2003, we furnished a current report on Form 8-K under Item 12 announcing our operating results for the quarter ended June 30, 2003.

On August 27, 2003 we filed a current report on Form 8-K under Item 5 announcing our adoption of a policy under which our executive officers and directors are only permitted to sell common stock pursuant to written trading plans established in accordance with Rule 10b5-1 under the Securities Exchange Act.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized as of October 27, 2003.

CENTENE CORPORATION

By: /s/ Michael F. Neidorff

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

By: /s/ Karey L. Witty

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

EXHIBIT 10.1

SECOND AMENDMENT
(DATED AND EFFECTIVE AUGUST 1, 2003)
TO
LOAN AGREEMENT
(THAT WAS EFFECTIVE MAY 1, 2002)
BY AND BETWEEN
LASALLE BANK NATIONAL ASSOCIATION,
AS LENDER,
AND
CENTENE CORPORATION,
AS BORROWER

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

1. DEFINITIONS; SECTION REFERENCES. The term Original Loan Agreement means the Loan Agreement dated as of May 1, 2002 between Borrower and Lender, as amended by that certain First Amendment thereto dated as of June 30, 2003 and effective as of May 1, 2003. The term this Amendment means this Second Amendment. The term Loan Agreement means the Original Loan Agreement as amended by this Amendment. Capitalized terms used and not otherwise defined herein have the meanings defined in the Loan Agreement. Section and Exhibit references are to sections of, and exhibits to, respectively, the Original Loan Agreement unless otherwise specified.

2. CONDITIONS TO EFFECTIVENESS OF THIS AMENDMENT. This Amendment is effective as of August 1, 2003, but only if the following conditions have been satisfied on or before August 1, 2003:

2.1. This Amendment has been executed by Borrower and Lender.

2.2. That certain Membership Interest Pledge Agreement regarding Borrower's membership interests in Centene Management Company LLC dated as of even date herewith has been executed by Borrower (and original certificates representing 100% of the outstanding membership interests of Centene Management Company LLC, together with membership interest powers duly executed in blank, have been delivered to Lender).

2.3. Borrower has delivered to Lender certificates of good standing for the following Persons, issued by the Secretary of State of the following states:

2.3.1. Borrower (Delaware and Missouri).

2.3.2. Centene Management Company LLC (Wisconsin).

2.4. Borrower has delivered to Lender a Certificate of the Secretary of Borrower certifying (i) that the Charter Documents of Borrower and each Subsidiary of Borrower (other than Centene Management Corporation) previously certified to Lender in connection with the execution of the Original Loan Agreement have not been amended, (ii) that resolutions adopted by the Board of Directors of Borrower, as applicable, authorizing the execution, delivery and performance of this Amendment and the documents described herein by Borrower and the performance of this Amendment and the transactions described herein by Borrower are attached to such certificate and remain in full force and effect, and (iii) the names, titles, and true signatures of the

incumbent corporate officers who are authorized to sign this Amendment or attest signatures or seals on this Amendment on behalf of Borrower.

2.5. File-stamped Certificate of Conversion for Centene Management Company LLC, certified by the Wisconsin Secretary of State, and a copy of the Operating Agreement of Centene Management Company LLC, certified by an officer or manager of Centene Management Company LLC.

2.6. An opinion of Borrower's counsel in form and substance satisfactory to Lender.

3. CONVERSION OF CENTENE MANAGEMENT CORPORATION INTO A LIMITED LIABILITY COMPANY. Lender hereby consents to the conversion of Centene Management Corporation into a Wisconsin limited liability company named Centene Management Company LLC.

4. AMENDMENTS TO ORIGINAL LOAN AGREEMENT. The Original Loan Agreement is hereby amended as follows:

4.1. COVERED PERSONS. Section 2.3 is amended by deleting the text thereof in its entirety and replacing it with the following: "The words

Covered Person, a Covered Person, any Covered Person, each Covered Person and every Covered Person refer to Borrower and each of its Subsidiaries separately, including Centene Management Company LLC, a Wisconsin limited liability company, Centene Corporation of Texas, a Texas corporation, Managed Health Services Insurance Corp., a Wisconsin corporation, Superior HealthPlan, Inc., a Texas corporation, Coordinated Care Corporation Indiana, Inc., an Indiana corporation, Managed Health Services Illinois, Inc., an Illinois corporation, MHS Consulting Corporation, a Wisconsin corporation, MHS Behavioral Health of Texas, Inc., a Texas corporation, Bankers Reserve Life Insurance Company of Wisconsin, a Wisconsin insurance company, University Health Plans, Inc., a New Jersey corporation, Cenphiny, Inc., a Delaware corporation, and Centene Finance Corporation, a Delaware corporation. The words Covered Persons refer to Borrower and its Subsidiaries, including each of the Persons specifically mentioned in the prior sentence, collectively."

5. REPRESENTATIONS AND WARRANTIES. Borrower hereby represents and warrants to Lender as of the date hereof that (i) this Amendment and each and every other document and instrument delivered by Borrower in connection with this Amendment (each, an Amendment Document and, collectively, the Amendment Documents) has been duly authorized by its Board of Directors, (ii) no consents are necessary from any third Person for its execution, delivery or performance of the Amendment Documents to which it is a party which have not been obtained and a copy thereof delivered to Lender, (iii) each of the Amendment Documents to which it is a party constitutes its legal, valid and binding obligation enforceable against it in accordance with its terms, except to the extent that the enforceability thereof against it may be limited by bankruptcy, insolvency, fraudulent conveyance, reorganization, moratorium or similar laws affecting the enforceability of creditors' rights generally or by equitable principles of general application (whether considered in an action at law or in equity), (iv) all of the representations and warranties contained in Section 12, as amended by this Amendment, are true and correct in all material respects with the same force and effect as if made on and as of the date of this Amendment, except that with respect to the representations and warranties made regarding financial data, such representations and warranties are hereby made with respect to the most recent Financial Statements and other financial data (in the form required by the Original Loan Agreement) delivered by it to Lender, and (v) there exists no Default or Event of Default under the Original Loan Agreement.

6. EFFECT OF AMENDMENT. The execution, delivery and effectiveness of this Amendment shall not operate as a waiver of any right, power or remedy of Lender under the Original Loan Agreement or any

of the other Loan Documents, nor constitute a waiver of any provision of the Original Loan Agreement or any of the other Loan Documents or any Existing Default or Event of Default, nor act as a release or subordination of the Security Interests of Lender under the Security Documents. Each reference in the Original Loan Agreement to the Agreement, hereunder, hereof, herein, or words of like import, shall be read as referring to the Original Loan Agreement as amended hereby. Each reference in the other Loan Documents to the Loan Agreement shall be read as referring to the Original Loan Agreement, as amended hereby.

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

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

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

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

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

12. INCORPORATION BY REFERENCE. Lender and Borrower hereby agree that all of the terms of the Loan Documents are incorporated in and made a part of this Amendment by this reference.

13. STATUTORY NOTICE - ORAL COMMITMENTS. Nothing contained in such notice shall be deemed to limit or modify the terms of the Loan Documents or this Amendment:

ORAL AGREEMENTS OR COMMITMENTS TO LOAN MONEY, EXTEND CREDIT OR TO FORBEAR FROM ENFORCING REPAYMENT OF A DEBT INCLUDING PROMISES TO EXTEND OR RENEW SUCH DEBT ARE NOT ENFORCEABLE. TO PROTECT YOU (BORROWER) AND US (CREDITOR) FROM MISUNDERSTANDING OR DISAPPOINTMENT, ANY AGREEMENTS WE REACH COVERING SUCH

MATTERS ARE CONTAINED IN THIS WRITING, WHICH IS THE COMPLETE AND EXCLUSIVE STATEMENT OF THE AGREEMENT BETWEEN US, EXCEPT AS WE MAY LATER AGREE IN WRITING TO MODIFY IT.

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

{remainder of page intentionally left blank}

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

BORROWER:

CENTENE CORPORATION

By: /s/ Karey L. Witty

Name: Karey L. Witty

Title: Senior Vice President, CFO and Treasurer

LENDER:

LASALLE BANK NATIONAL ASSOCIATION

By: /s/ Ann B. O'Shaughnessy

Name: Ann B. O'Shaughnessy

Title: First Vice President

Exhibit 31.1

CERTIFICATIONS

I, Michael F. Neidorff, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Centene Corporation;

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

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

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) 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 report is being prepared;

   b) [Paragraph omitted in accordance with SEC transition instructions contained in SEC Release 34-47986];

   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 functions):

   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.

Date: October 27, 2003

/s/ Michael F. Neidorff

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

Exhibit 31.2

CERTIFICATIONS

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 Rules 13a-15(e) and 15d-15(e)) 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 report is being prepared;

   b) [Paragraph omitted in accordance with SEC transition instructions contained in SEC Release 34-47986];

   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 functions):

   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.

Date: October 27, 2003

/s/ Karey L. Witty

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

Exhibit 32.1

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

In connection with the Quarterly Report on Form 10-Q of Centene Corporation (the "Company") for the period ended September 30, 2003 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), the undersigned, Michael F. Neidorff, President and Chief Executive Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

Date: October 27, 2003

/s/ Michael F. Neidorff

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

Exhibit 32.2

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

In connection with the Quarterly Report on Form 10-Q of Centene Corporation (the "Company") for the period ended September 30, 2003 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 and Treasurer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

Date: October 27, 2003

/s/ Karey L. Witty

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