CENTENE CORP
Form S-3/A
July 29, 2003

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As filed with the Securities and Exchange Commission on July 29, 2003

Registration No. 333-107247

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

AMENDMENT NO. 1
TO

Form S-3

REGISTRATION STATEMENT UNDER THE SECURITIES ACT OF 1933

Centene Corporation

(Exact Name of Registrant as Specified in its Charter)

Delaware	**6324**	**04-1406317**
(State or Other Jurisdiction of Incorporation or Organization)	*(Primary Standard Industrial Classification Code Number)*	*(I.R.S. Employer Identification No.)*

7711 Carondelet Avenue, Suite 800

Saint Louis, Missouri 63105 (314) 725-4477
(Address, Including Zip Code, and Telephone Number, Including Area Code, of Registrant s Principal Executive Offices)

Michael F. Neidorff
Centene Corporation
7711 Carondelet Avenue, Suite 800
Saint Louis, Missouri 63105 (314) 725-4477
(Name, Address, Including Zip Code, and Telephone Number, Including Area Code, of Agent for Service)

Copies to:

Mark L. Johnson, Esq.	**Alejandro E. Camacho, Esq.**
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60 State Street	**200 Park Avenue**
Boston, Massachusetts 02109	**New York, New York 10166-0153**
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Approximate date of commencement of proposed sale to the public: As soon as practicable after this registration statement becomes effective.

If the only securities being registered on this form are being offered pursuant to dividend or interest reinvestment plans, please check the following box. o

If any of the securities being registered on this form are to be offered on a delayed or continuous basis pursuant to Rule 415 under the Securities Act of 1933, other than securities offered only in connection with dividend or interest reinvestment plans, check the following box. o

If this form is filed to register additional securities for an offering pursuant to Rule 462(b) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. o
333-_____.

If this form is a post-effective amendment filed pursuant to Rule 462(c) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. o 333-_____.

If delivery of the prospectus is expected to be made pursuant to Rule 434, check the following box. o

The registrant hereby amends this registration statement on such date or dates as may be necessary to delay its effective date until the registrant shall file a further amendment which specifically states that this registration statement shall thereafter become effective in accordance with Section 8(a) of the Securities Act of 1933 or until the registration statement shall become effective on such date as the Commission, acting pursuant to said Section 8(a), may determine.

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The information in this prospectus is not complete and may be changed. We may not sell these securities until the registration statement filed with the Securities and Exchange Commission is effective. This prospectus is not an offer to sell these securities and is not soliciting an offer to buy these securities in any state where the offer or sale is not permitted.

Subject to Completion, dated July 29, 2003.

PROSPECTUS

3,000,000 Shares

(CENTENE CORPORATION LOGO)

Common Stock

We are offering 3,000,000 shares of common stock.

Our common stock is quoted on the Nasdaq National Market under the symbol CNTE . On July 28, 2003, the last reported sale price of our common stock on the Nasdaq National Market was $29.08 per share.

Investing in our common stock involves risks. See Risk Factors beginning on page 5.

	Per Share	Total
Public offering price	$	$
Underwriting discount	$	$
Proceeds to Centene (before expenses)	$	$

We have granted the underwriters a 30-day option to purchase up to 450,000 additional shares of common stock on the same terms and conditions as set forth above to cover over-allotments, if any.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of these securities or passed upon the adequacy or accuracy of this prospectus. Any representation to the contrary is a criminal offense.

The underwriters expect to deliver the shares on or about , 2003.

Joint Book-Running Managers

LEHMAN BROTHERS **SG COWEN**

THOMAS WEISEL PARTNERS LLC

STIFEL, NICOLAUS & COMPANY
INCORPORATED

, 2003

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You should rely only on the information included or incorporated by reference in this prospectus. We have not authorized anyone to provide you with information that is different from that contained in this prospectus. This prospectus is not an offer to sell or a solicitation of an offer to buy shares in any jurisdiction where such offer or any sale of shares would be unlawful. The information in this prospectus is complete and accurate only as of the date on the front cover of this prospectus, regardless of the time of delivery of this prospectus or of any sale of shares.

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PROSPECTUS SUMMARY

This summary highlights information included elsewhere or incorporated by reference in this prospectus and does not contain all of the information you should consider in making your investment decision. You should read this summary together with the more detailed information, including our consolidated financial statements and the related notes, included elsewhere or incorporated by reference in this prospectus.

Centene Corporation

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. We believe our local approach to managing our health plans, including provider and member services, enables us to provide accessible, high quality, culturally-sensitive healthcare services to our members. Our disease management, educational and other initiatives are designed to help members best utilize the healthcare system to ensure they receive appropriate, medically necessary services and effective management of routine health problems, as well as more severe acute and chronic conditions. We combine our decentralized, local approach with centralized finance, information systems, claims processing and medical management support functions.

Our Approach

Our approach to managed care is based on the following key attributes:

Medicaid Expertise. Over the last 19 years, we have developed a specialized Medicaid expertise that has helped us establish and maintain strong relationships with our constituent communities of members, providers and state governments. We have implemented programs developed to achieve savings for state governments and improve medical outcomes for members by reducing inappropriate emergency room use, inpatient days and high cost interventions, as well as by managing care of chronic illnesses. We do this primarily by providing nurse case managers who support our physicians in implementing disease management programs and by providing incentives for our physicians to provide preventive care on a regular basis. We recruit and train staff and providers who are attentive to the needs of our members and who are experienced in working with culturally diverse, low-income Medicaid populations. Our experience in working with state regulators helps us to implement and deliver our programs and services efficiently and affords us opportunities to provide input on Medicaid industry practices and policies in the states in which we operate.

Localized Services, Support and Branding. We provide access to healthcare services through local networks of providers and staff who focus on the cultural norms of their individual communities. Our systems and procedures have been designed to address these community-specific challenges through outreach, education, transportation and other member support activities. We use locally recognized plan names, and we tailor our materials and processes to meet the needs of the communities and the state programs we serve. Our approach to community-based service results in local accountability and solidifies our decentralized management and operational structure.

Collaborative Approach with States. Our approach is to work with state agencies on redefining benefit levels, eligibility requirements and provider fee schedules in order to maximize the number of uninsured individuals covered through Medicaid and SCHIP while maintaining adequate levels of provider compensation.

Physician-Driven Approach. We have implemented a physician-driven approach in which our physicians are actively engaged in developing and implementing our healthcare delivery policies and strategies. Our local boards of directors, which help shape the character and quality of our organization, have significant provider representation in each of our principal geographic markets. This approach is designed to eliminate unnecessary costs, improve service to our members and simplify the administrative burdens on our providers. It has enabled us to strengthen our provider networks through improved physician recruitment and retention that, in turn, have helped to increase our membership base.

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Efficiency of Business Model. We have designed our business model to allow us to readily add new members in our existing markets and expand into new regions in which we may choose to operate. The combination of our decentralized local approach to operating our health plans and our centralized finance, information systems, claims processing and medical management support functions allows us to quickly and economically integrate new business opportunities.

Specialized Systems and Technology. Through our specialized information systems, we are able to strengthen our relationships with providers and states, which help us to grow our membership base. These systems also help us identify needs for new healthcare programs. Physicians can use our claims, utilization and membership data to manage their practices more efficiently, and they benefit from our timely and accurate payments. State agencies can use data from our information systems to demonstrate that their Medicaid populations are receiving quality healthcare in an efficient manner.

Complementary Business Lines. We have begun to broaden our service offerings to address areas that we believe have been traditionally underserved by Medicaid managed care organizations. Effective March 1, 2003, we acquired a 63.7% interest in Group Practice Affiliates, a behavioral health services company, and purchased contract and name rights of ScriptAssist, a medication compliance company. We believe other business lines, such as our NurseWise triage program, will allow us to expand our services and diversify our sources of revenue.

Our Strategy

Our objective is to become the leading national Medicaid managed care organization. We intend to achieve this objective by implementing the following key components of our strategy:

increase penetration of existing state markets;

develop and acquire additional state markets;

address emerging state needs;

diversify our business lines; and

leverage our information technologies to enhance operating efficiencies.

Additional Considerations

Nearly all of our revenues come from Medicaid premiums paid by the states of Wisconsin, Texas, Indiana and New Jersey. Our operating results depend significantly on Medicaid program funding, premium levels, eligibility standards, reimbursement levels and other regulatory provisions established by the federal government and the governments of the states in which we operate. Because we operate in a limited number of markets, any termination of, or failure to renew, our existing contracts or any regulatory changes affecting those markets could materially reduce our revenues and profitability. Moreover, because the premiums we receive are established by contract, our profitability depends on our ability to predict and effectively manage the costs of healthcare services delivered to our members. For a discussion of these and other risks relating to an investment in our common stock, see Risk Factors below.

Corporate Information

We were organized in Wisconsin in 1993 and reincorporated in Delaware in 2001. We initially were formed to serve as a holding company for a Medicaid managed care line of business that has been operating in Wisconsin since 1984. Our corporate office is located at 7711 Carondelet Avenue, Suite 800, Saint Louis, Missouri 63105, and our telephone number is (314) 725-4477. The address of our website is *www.centene.com*. **The information on our website is not part of this prospectus.**

CENTENE and NURSEWISE are our registered service marks, and the Centene logo is our service mark. We have also filed an application with the U.S. Patent and Trademark Office to register START SMART FOR YOUR BABY as our trademark. This prospectus also contains trademarks, service marks and trade names of other companies.

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The Offering

Common stock offered by Centene	3,000,000 shares
Common stock to be outstanding after the offering	19,606,059 shares
Nasdaq National Market symbol	CNTE
Use of proceeds	We intend to use our net proceeds of this offering for working capital and other general corporate purposes, which may include acquisitions of businesses, assets and technologies complementary to our business.

The number of shares of common stock to be outstanding after the offering is based on 16,606,059 shares of common stock outstanding as of July 28, 2003. It excludes:

717,216 shares subject to options vested as of July 28, 2003 and having a weighted average exercise price of $3.28 per share;

1,533,428 shares subject to options unvested (or exercisable only to acquire restricted shares that would be subject to future vesting) as of July 28, 2003 and having a weighted average exercise price of $12.42 per share; and

2,450,765 additional shares reserved as of July 28, 2003 for future issuance under our stock plans.

Except where we state otherwise, the information we present in this prospectus:

reflects a three-for-two split of our common stock effected as a common stock dividend paid as of July 11, 2003; and

assumes the underwriters do not exercise their over-allotment option.

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Summary Consolidated Financial and Operating Data

You should read the following summary consolidated data in conjunction with our consolidated financial statements and related notes included elsewhere in this prospectus.

	Six Months Ended June 30,		Year Ended December 31,		
	2003	2002	2002	2001	2000
	(in thousands, except share data)				
Statement of Operations Data:					
Premiums(1)	$ 359,112	$ 203,152	$ 461,030	$ 326,184	$ 216,414
Services	4,554	211	457	385	4,936
Total revenues	363,666	203,363	461,487	326,569	221,350
Medical costs	299,311	167,053	379,468	270,151	182,495
Cost of services	3,588	168	341	329	135
General and administrative expenses	40,284	22,162	50,072	37,617	32,200
Total operating expenses	343,183	189,383	429,881	308,097	214,830
Net earnings	14,869	9,533	25,621	12,895	7,728
Net earnings attributable to common stockholders	14,869	9,533	25,621	12,428	7,236
Net earnings per common share:					
Basic	$ 0.91	$ 0.62	$ 1.63	$ 5.98	$ 5.35
Diluted	$ 0.83	$ 0.56	$ 1.47	$ 1.07	$ 0.76
Weighted average common shares outstanding:					
Basic	16,409,291	15,311,427	15,716,040	2,078,099	1,352,289
Diluted	17,829,558	17,152,775	17,466,116	12,029,246	10,229,393
Operating Data:					
Health benefits ratio(2)	83.3%	82.2%	82.3%	82.8%	84.3%
General and administrative expenses ratio(3)	11.1%	11.0%	10.9%	11.6%	14.6%
Members at end of period	438,700	278,600	409,600	235,100	194,200

(1) Premiums consist of payments we receive from states to provide health benefits to members and do not include investment income.

(2) Health benefits ratio represents medical costs as a percentage of premiums.

(3) General and administrative expenses ratio represents general and administrative expenses as a percentage of total revenues.

	June 30, 2003	
	Actual	As Adjusted
	(in thousands)	
Balance Sheet Data:		
Cash, cash equivalents and short-term investments	$ 52,827	$135,180
Total assets	220,414	302,767
Long-term debt		
Total stockholders equity	117,825	200,178

The preceding table summarizes our balance sheet data at June 30, 2003:

on an actual basis; and

as adjusted to reflect our sale of the 3,000,000 shares of common stock offered by us at an assumed price of $29.08 per share, after deducting the estimated underwriting discount and our estimated offering expenses, and the application of our estimated net proceeds.

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RISK FACTORS

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

Risks Related to Being a Regulated Entity

Reductions in Medicaid 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 healthcare 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 August 31, 2003 and June 30, 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;

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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%. To date we have not been required to pay any rebate under either the Texas or New Jersey regulations. 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 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 an exception contained in the federal Medicaid reimbursement regulations permitting states to reimburse non-state government-owned or operated hospitals for inpatient and outpatient hospital services at amounts up to 150 percent of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles. The upper payment limit was reduced to 100 percent 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 would entitle patients to seek monetary damages for violations of the privacy rules.

Compliance with new government regulations may require us to make significant expenditures.

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

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healthcare claims and payment transactions submitted or received electronically. We are required to comply with the new regulation by October 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 enhance the privacy initiatives of GPA, which we acquired in March 2003, in order for these initiatives to be consistent with the privacy initiatives 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.

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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 83.3% for the six months ended June 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 incurred but not reported, or 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

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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.

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We derive all 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.

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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.

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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.

Risks Related to This Offering and Ownership of Our Common Stock

Volatility of our stock price could cause you to lose all or part of your investment.

The market price of our common stock, like that of the common stock of others in our industry, may be highly volatile. The stock market in general has recently experienced extreme price and volume fluctuations, and this volatility has affected the market prices of securities of other companies for reasons frequently unrelated, or disproportionate, to the operating performance of those companies. The market price of our common stock may fluctuate significantly in response to the following factors, some of which are beyond our control:

- state and federal budget decreases;
- changes in securities analysts estimates of our financial performance;
- changes in market valuations of similar companies, including commercial managed care organizations;
- variations in our quarterly operating results;
- acquisitions and strategic partnerships;
- adverse publicity regarding managed care organizations;

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government action regarding Medicaid eligibility;

changes in state mandatory Medicaid programs;

changes in our management;

broad fluctuations in stock market prices and volume; and

general economic conditions, including inflation and unemployment rates.

Investors may not be able to resell their shares of our common stock following periods of volatility because of the market s adverse reaction to the volatility. We cannot assure you that our stock will trade at the same levels as the stock of other companies in our industry or that the market in general will sustain its current prices.

Our corporate documents and provisions of Delaware law may prevent a change in control or management that stockholders may consider desirable.

Section 203 of the Delaware General Corporation Law, laws of states in which we operate, and our charter and by-laws contain provisions that might enable our management to resist a takeover of our company. These provisions could have the effect of delaying, deferring, or preventing a change in control of Centene or a change in our management that stockholders may consider favorable or beneficial. These provisions could also discourage proxy contests and make it more difficult for you and other stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock.

Certain of our financial statements have been audited by Arthur Andersen LLP, and the ability to recover damages from Arthur Andersen may be limited.

Prior to June 18, 2002, Arthur Andersen LLP served as our independent public accountants. On March 14, 2002, Arthur Andersen was indicted on federal obstruction of justice charges arising from the government s investigation of Enron Corporation. On June 15, 2002, Arthur Andersen was convicted of those charges and the firm ceased practicing before the SEC on August 31, 2002.

Our inability to obtain the consent of Arthur Andersen to include its report on certain financial statements audited by Arthur Andersen and included in this prospectus may limit your recovery against Arthur Andersen under the securities laws. SEC rules require us to include or incorporate by reference in this prospectus certain historical financial statements for the years ended December 31, 2001 and 2000 that were audited by Arthur Andersen. Since our former engagement partner and audit manager have left Arthur Andersen and Arthur Andersen has ceased its SEC practice, we have not been able to obtain the consent of Arthur Andersen to the inclusion of its audit report in this prospectus and will not be able to obtain Arthur Andersen s consent in the future. The absence of this consent may limit any recovery to which you might be entitled against Arthur Andersen under Section 11 of the Securities Act.

It is also likely that events arising out of the conviction of Arthur Andersen would adversely affect its ability to satisfy any claims we may have arising from its provision of auditing and other services to us.

You will pay a much higher price per share than the book value of our common stock.

If you purchase our common stock in this offering, you will incur immediate and substantial dilution. You will pay a price per share that exceeds by $19.54 the per share net tangible book value of our assets immediately following the offering (based on net tangible book value as of June 30, 2003, on an as adjusted basis, and shares of common stock outstanding as of July 28, 2003 and an assumed offering price of $29.08).

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FORWARD-LOOKING STATEMENTS

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

Actual results may differ from projections or estimates due to a variety of important factors. Our results of operations and projections of future earnings depend in large part on accurately predicting and effectively managing health benefits and other operating expenses. A variety of factors, including competition, changes in healthcare practices, changes in federal or state laws and regulations or their interpretations, inflation, provider contract changes, new technologies, government-imposed surcharges, taxes or assessments, reduction in provider payments by governmental payors, major epidemics, disasters and numerous other factors affecting the delivery and cost of healthcare, such as major healthcare providers inability to maintain their operations, may in the future affect our ability to control our medical costs and other operating expenses. Governmental action or business conditions could result in premium revenues not increasing to offset any increase in medical costs and other operating expenses. Once set, premiums are generally fixed for one year periods and, accordingly, unanticipated costs during such periods cannot be recovered through higher premiums. The expiration, cancellation or suspension of our Medicaid managed care contracts by the state governments would also negatively impact us. Due to these factors and risks, we cannot assure you with respect to our future premium levels or our ability to control our future medical costs.

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USE OF PROCEEDS

We estimate that our net proceeds of our sale of the 3,000,000 shares of common stock offered by us will be approximately $82.4 million ($94.8 million if the underwriters exercise their over-allotment option in full), assuming an offering price of $29.08 per share and after deducting the estimated underwriting discount and our estimated offering expenses.

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. For example, we have three pending matters for which we may use a portion of the net proceeds:

In June 2003 we entered into a definitive agreement under which we expect to acquire, in the third quarter of 2003, the Medicaid-related contract rights of HMO Blue Texas in the San Antonio, Texas market for a purchase price of $1.0 million in cash.

We may elect, at any time prior to September 1, 2003, to purchase those shares of UHP that we do not currently own, for a cash purchase price of $2.6 million, as described below under Management s Discussion and Analysis of Financial Condition and Results of Operations Overview.

We are party to a non-binding letter of intent that would expand our managed care programs into a new state for a proposed purchase price of less than $7.0 million in cash. This proposed acquisition is in an early stage of diligence and negotiation, and there can be no assurance that the acquisition will be completed.

Although we have evaluated other possible acquisitions from time to time and seek to maintain a pipeline of potential acquisition candidates, we currently have no other commitments or agreements to make any acquisitions, and we cannot assure you that we will make any other acquisitions in the future.

We also may apply proceeds to fund working capital to:

increase market penetration within our current service areas;

pursue opportunities for the development of new markets;

expand services and products available to our members; and

strengthen our capital base by increasing the statutory capital of our health plan subsidiaries.

We have not determined the amount of net proceeds to be used specifically for the foregoing purposes. As a result, our management will have broad discretion to allocate our net proceeds of this offering. Pending application of our net proceeds, we intend to invest our net proceeds in investment-grade, interest-bearing instruments, which may include repurchase agreements and high-grade municipal and corporate notes.

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PRICE RANGE OF COMMON STOCK

Our common stock has been quoted on the Nasdaq National Market under the symbol CNTE since December 13, 2001. Prior to that time, there was no public market for the common stock. The following table sets forth, for the periods indicated, the high and low sales prices per share of the common stock as reported on the Nasdaq National Market.

	High	Low
2001		
Fourth Quarter (commencing December 13, 2001)	$15.40	$ 9.51
2002		
First Quarter	15.71	12.07
Second Quarter	20.73	15.07
Third Quarter	20.45	14.47
Fourth Quarter	23.65	16.97
2003		
First Quarter	23.23	14.90
Second Quarter	26.43	18.77
Third Quarter (through July 28, 2003)	29.64	24.81

On July 28, 2003, the last reported sale price of the common stock on the Nasdaq National Market was $29.08. As of July 28, 2003, there were 23 stockholders of record.

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CAPITALIZATION

The following table shows our capitalization as of June 30, 2003:

- on an actual basis; and
- as adjusted to reflect our sale of the 3,000,000 shares of common stock offered by us at an assumed price of $29.08 per share, after deducting the estimated underwriting discount and our estimated offering expenses, and the application of our estimated net proceeds.

You should read this table in conjunction with our consolidated financial statements and the related notes included elsewhere in this prospectus and Management s Discussion and Analysis of Financial Condition and Results of Operations below.

	June 30, 2003	
	Actual	As Adjusted
	(in thousands)	
Long-term debt	$	$
Stockholders equity:		
Undesignated preferred stock, $.001 par value; 10,000,000 shares authorized and no shares issued or outstanding, actual and as adjusted		
Common stock, $.001 par value; 40,000,000 shares authorized and 16,606,059 shares issued and outstanding, actual; 40,000,000 shares authorized and 19,606,059 shares issued and outstanding, as adjusted	17	20
Additional paid-in capital	73,026	155,376
Net unrealized gain on investments, net of tax	1,204	1,204
Retained earnings	43,578	43,578
Total stockholders equity	117,825	200,178
Total capitalization	$117,825	$200,178

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SELECTED CONSOLIDATED FINANCIAL DATA

The following selected consolidated financial data should be read in connection with, and are qualified by reference to, the consolidated financial statements and related notes and Management s Discussion and Analysis of Financial Condition and Results of Operations included elsewhere in this prospectus. The data for the year ended, and as of, December 31, 2002 are derived from consolidated financial statements audited by PricewaterhouseCoopers LLP and included elsewhere in this prospectus. The data for the years ended, and as of, December 31, 2001 and 2000 are derived from consolidated financial statements audited by Arthur Andersen LLP and included elsewhere in this prospectus. The data for the years ended, and as of, December 31, 1999 and 1998 are derived from audited consolidated financial statements not included in this prospectus. The data for the six months ended, and as of, June 30, 2003 are derived from unaudited consolidated financial statements included elsewhere in this prospectus. The unaudited consolidated financial statements have been prepared on the same basis as the audited consolidated financial statements and, in the opinion of our management, include all adjustments, consisting only of normal recurring adjustments, necessary for a fair presentation of the information set forth therein. Operating results for the six months ended June 30, 2003 are not necessarily indicative of operating results to be expected for the full year.

	Six Months Ended June 30,		Year Ended December 31,				
	2003	2002	2002	2001	2000	1999	1998
	(in thousands, except share data)						
Statement of Operations Data:							
Revenues:							
Premiums	$ 359,112	$ 203,152	$ 461,030	$ 326,184	$ 216,414	$ 200,549	$ 149,577
Services	4,554	211	457	385	4,936	880	861
Total revenues	363,666	203,363	461,487	326,569	221,350	201,429	150,438
Operating expenses:							
Medical costs	299,311	167,053	379,468	270,151	182,495	178,285	132,199
Cost of services	3,588	168	341	329	135		
General and administrative expenses	40,284	22,162	50,072	37,617	32,200	29,756	25,066
Total operating expenses	343,183	189,383	429,881	308,097	214,830	208,041	157,265
Earnings (losses) from operations	20,483	13,980	31,606	18,472	6,520	(6,612)	(6,827)
Other income (expense):							
Investment and other income, net	2,231	1,891	9,575	3,916	1,784	1,623	1,794
Interest expense	(31)	(11)	(45)	(362)	(611)	(498)	(771)
Equity in earnings (losses) from joint ventures					(508)	3	(477)
Earnings (losses) from continuing operations before income taxes	22,683	15,860	41,136	22,026	7,185	(5,484)	(6,281)
Income tax expense (benefit)	8,695	6,327	15,631	9,131	(543)		(1,542)
Minority interest	881		116				
Earnings (losses) from continuing operations	14,869	9,533	25,621	12,895	7,728	(5,484)	(4,739)
Loss from discontinued operations, net						(3,927)	(2,223)

Net earnings (losses)	14,869	9,533	25,621	12,895	7,728	(9,411)	(6,962)
Accretion of redeemable preferred stock				(467)	(492)	(492)	(122)
Net earnings (losses) attributable to common stockholders	$ 14,869	$ 9,533	$ 25,621	$ 12,428	7,236	$ (9,903)	$ (7,084)
Net earnings (losses) from continuing operations per common share:							
Basic	$ 0.91	$ 0.62	$ 1.63	$ 5.98	$ 5.35	$ (4.42)	$ (3.10)
Diluted	$ 0.83	$ 0.56	$ 1.47	$ 1.07	$ 0.76	$ (4.42)	$ (3.10)
Net earnings (losses) per common share:							
Basic	$ 0.91	$ 0.62	$ 1.63	$ 5.98	$ 5.35	$ (7.33)	$ (4.52)
Diluted	$ 0.83	$ 0.56	$ 1.47	$ 1.07	$ 0.76	$ (7.33)	$ (4.52)
Weighted average common shares outstanding:							
Basic	16,409,291	15,311,427	15,716,040	2,078,099	1,352,289	1,351,416	1,566,651
Diluted	17,829,558	17,152,775	17,466,116	12,029,246	10,229,393	1,351,416	1,566,651

	June 30, 2003	December 31,				
		2002	2001	2000	1999	1998
		(in thousands)				
Balance Sheet Data:						
Cash, cash equivalents and short-term investments	$ 52,827	$ 69,227	$ 90,036	$26,423	$ 23,663	$21,525
Total assets	220,414	210,327	131,366	66,017	52,207	45,727
Long-term debt, net of current portion				4,000	4,000	4,000
Redeemable convertible preferred stock				18,878	18,386	17,700
Total stockholders equity (deficit)	117,825	102,183	64,089	(8,834)	(16,367)	(6,196)

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MANAGEMENT S DISCUSSION AND ANALYSIS OF

FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this prospectus. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth above under Risk Factors.

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 March 1, 2003, we acquired a 63.7% ownership interest in Group Practice Affiliates, or GPA. GPA, an Atlanta, Georgia-based behavioral healthcare services company, serves over 700,000 individuals in three states through a combination of networks, groups and schools, including a portion of our membership. The joint venture investment is consistent with our strategy to provide diversified medical services to the managed Medicaid population. We paid $4.3 million in cash for our investment in GPA. We may be required to make an additional investment of up to $1.7 million by June 2004 based on GPA s 2003 performance and other factors. Conversely, certain post-closing adjustments based on GPA s 2003 performance and other factors may result in our ownership percentage increasing. After a three-year term of the joint venture, we will have the option to acquire any remaining interest in GPA. Similarly the minority interest partners will have the option to sell any remaining interest in GPA to us after the three-year term. Any purchase or sale of the remaining partners interest will be made at a price equal to the fair market value of the partners interests as of the date of the notice.

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, which continues to own the remaining capital stock of UHP. UHP is a managed health plan operating in 15 counties in New Jersey. We paid an aggregate purchase price of $10.6 million for our interest in UHP. In connection with the acquisition, we entered into an investor rights agreement with UMDNJ providing that, among other things:

- We have the right, exercisable at any time prior to September 1, 2003, to purchase the remaining shares of UHP held by UMDNJ for a cash purchase price of $2.6 million.

- If we do not exercise the right described above, the remaining shares of UHP held by UMDNJ will be exchanged on December 1, 2005 for a purchase price payable in either, at our election, shares of our common stock or cash. The purchase price would equal the greater of (a) $2.6 million or (b) the product of (1) the enterprise value of UHP as of December 1, 2005 and (2) the percentage of the outstanding UHP common stock (on a fully diluted basis) then represented by the shares owned by UMDNJ.

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

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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.

In June 2003 we entered into a definitive agreement under which we expect to acquire, in the third quarter of 2003, the Medicaid-related contract rights of HMO Blue Texas in the San Antonio, Texas market for a purchase price of $1.0 million in cash. This acquisition will add 21,000 members to our existing base of 24,000 members in San Antonio.

With our acquisition of 63.7% 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 services, including our behavioral health, nurse triage and pharmacy compliance functions. Our consolidated financial statements for the six months ended June 30, 2003 and prior periods, including 2002, 2001 and 2000, are not presented by segment because revenues and earnings from operations from third parties from our Specialty Services segment represented less than 4.0% of consolidated revenues and earnings from operations for each such period.

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 our 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. From 1998 to 2000, however, we provided Medicaid services in certain regions of Indiana as a subcontractor with Maxicare Indiana, Inc. In June 2001, the Insurance Commissioner of the Indiana Department of Insurance declared Maxicare insolvent and ordered Maxicare into liquidation. As a result, we maintained an allowance for uncollectible receivables in the amount of $2.7 million to fully reserve for all receivables from Maxicare as of December 31, 2001. In 2002, subsequent to a release and settlement agreement with Maxicare and the Indiana Insurance Commissioner that requires no payment by either Maxicare or us, we wrote off the entire balance of the receivable from Maxicare as uncollectible and reduced the related allowance for doubtful accounts.

The primary driver of our increasing revenues has been membership growth. We have increased our membership through internal growth and acquisitions. From December 31, 2000 to June 30, 2003, we increased our membership by 126%. The following table sets forth our membership by state:

	June 30, 2003	December 31, 2002	December 31, 2001	December 31, 2000
Wisconsin	145,600	133,000	114,300	60,200
Texas	131,400	118,000	54,900	26,000
Indiana	109,000	105,700	65,900	108,000
New Jersey	52,700	52,900		
Total	438,700	409,600	235,100	194,200

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

	June 30, 2003	December 31, 2002	2001	2000
Medicaid (excluding SSI)	361,700	336,100	210,900	183,500
SCHIP	68,800	65,900	21,800	9,800
SSI	8,200	7,600	2,400	900
Total	438,700	409,600	235,100	194,200

In 2002, our membership increased by 24,000 members in Texas due to the purchase of SCHIP contract rights from Texas Universities Health Plan. In addition, two competing plans exited the Austin, Texas market during 2002. As a result, our Texas plan increased its membership by 28,000 lives. 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 reprocurement process scheduled for mid-2004. We entered the New Jersey market through our acquisition of 80% of the equity of UHP in December 2002. The remaining membership increases in our Wisconsin, Texas and Indiana markets in 2002 resulted from additions to our provider network and growth in the number of Medicaid beneficiaries.

In 2001, our membership in Indiana declined due to a subcontracting provider organization terminating a percent-of-premium arrangement, which was our only contract of that type. Separately, we entered into agreements with Humana that resulted in the transfer to us of 35,000 members in Wisconsin and 30,000 members in Texas.

In 2000, a competitor in our Wisconsin market terminated its participation in the Medicaid program benefiting our enrollment growth. Our membership growth in the northern and central regions of Indiana was offset by our decision to reduce our participation in the southern region. Our El Paso health plan achieved sizable growth because we were named the default health plan in this area and enrolled a majority of the members who failed to select a specific plan.

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 claim costs will not materially differ from our estimates.

Our results of operations depend on our ability to manage expenses related to health benefits and to accurately predict costs incurred. Our health benefits ratio 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:

	Six Months Ended June 30,		Year Ended December 31,		
	2003	2002	2002	2001	2000
Medicaid (excluding SSI)	82.4%	82.2%	82.2%	82.8%	84.3%
SSI	103.7		100.7		

Total	83.3	82.2	82.3	82.8	84.3

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While our core Medicaid business remained consistent between periods, the addition of the SSI members in New Jersey in December 2002 has caused our health benefits ratio 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 and our membership base grows within the state of New Jersey as well as in new 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, 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:

	Six Months Ended June 30,		Year Ended December 31,		
	2003	2002	2002	2001	2000
Medicaid Managed Care	10.4%	11.0%	10.9%	11.6%	14.6%
Specialty Services	30.2				
Total	11.1	11.0	10.9	11.6	14.6

The improvement in the general and administrative expenses ratio reflects growth in membership and leveraging of our overall infrastructure. For example, the decrease in our general and administrative ratio over the past two years in part reflects our efforts to increase claims processing efficiencies through our centralized support functions. As a result, our days in claims payable, which is a calculation of medical claims liabilities at the end of the quarter divided by average claims expense per calendar day for such quarter, decreased from 73.4 days at December 31, 2001 to 71.8 at December 31, 2002. Net of the effects of our acquisition of 80% of the capital stock of UHP on December 1, 2002, our days in claims payable would have been 64.5 days at December 31, 2002.

Other Income (Expense)

Other income (expense) consists principally of investment and other income, interest expense and equity in earnings (losses) from joint ventures.

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 reported in 2001 and 2000 primarily reflected interest paid on our subordinated notes, which we repaid in full in December 2001. Interest expense reported in the six months ended June 30, 2003 and in 2002 reflects non-use fees paid to a bank in conjunction with our credit facility.

Equity in earnings (losses) from joint ventures principally represented our share of operating results from Superior HealthPlan, which we formed with Community Health Centers Network in 1997. From 1998 through 2000, we owned 39% of Superior, and therefore accounted for the investment under the equity method of accounting. Effective January 1, 2001, we entered into an agreement to purchase an additional 51% of Superior. We also agreed to purchase from TACHC GP, Inc. a term note pursuant to which Superior owed TACHC $160,000. As a result of entering into this agreement, we began accounting for our investment in Superior using consolidation accounting. We therefore no longer reflect any operations of Superior in equity in earnings (losses) from joint ventures, and we eliminate

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in consolidation all administrative fees from Superior. In addition, in December 2001 we acquired the remaining 10% equity interest in Superior in exchange for 10,715 shares of our common stock.

Critical Accounting Policies

Our significant accounting policies are more fully described in note 3 to our annual consolidated financial statements included elsewhere herein. Two of our accounting policies are particularly important to the portrayal of our financial position and results of operations and require the application of significant judgment by our management; as a result they are subject to an inherent degree of uncertainty.

Medical Claims Liabilities

Our medical costs include estimates for claims received but not yet adjudicated, estimates for claims incurred but not yet received and estimates for the costs necessary to process unpaid claims. We, together with our independent actuaries, estimate medical claims liabilities using actuarial methods based upon historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors. These estimates are continually reviewed and adjustments, if necessary, are reflected in the period known.

In applying this policy, our management uses its judgment to determine the assumptions to be used in the determination of the required estimates. While we believe these estimates are appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. The estimates are based on our historical experience, terms of existing contracts, our observance of trends in the industry, information provided by our customers and information available from other outside sources, as appropriate.

The change in medical claims liabilities is summarized as follows:

	Year Ended December 31,		
	2002	2001	2000
Balance, January 1	$ 59,565	$ 45,805	$ 37,339
Acquisitions	16,230	5,074	
Incurred related to:			
Current year	399,141	289,133	188,034
Prior years	(19,673)	(18,982)	(5,539)
Total incurred	379,468	270,151	182,495
Paid related to:			
Current year	326,636	230,216	146,360
Prior years	37,446	31,249	27,669
Total paid	364,082	261,465	174,029
Balance, December 31	$ 91,181	$ 59,565	$ 45,805

Acquisitions in 2002 include reserves acquired in connection with our acquisition of 80% of the outstanding capital stock of UHP. Acquisitions in 2001 include reserves acquired in connection with our acquisition of the remaining shares of Superior HealthPlan.

Changes in estimates of incurred claims for prior years recognized during 2002, 2001 and 2000 were attributable to favorable development in all of our markets, including lower than anticipated utilization of medical services.

Intangible Assets

We have made several acquisitions since 2001 that collectively have resulted in our recording of a significant amount of intangible assets. These intangible assets represent the excess of cost over the fair

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market value of net assets acquired in purchase transactions and consist of purchased contract rights, provider contracts and goodwill. Purchased contract rights are amortized using the straight-line method over periods ranging from 60 to 120 months. Provider contracts are amortized using the straight-line method over 120 months.

Our management evaluates whether events or circumstances have occurred that may affect the estimated useful life or the recoverability of the remaining balance of goodwill and other identifiable intangible assets. Impairment of an intangible asset is triggered when the estimated future undiscounted cash flows (excluding interest charges) do not exceed the carrying amount of the intangible asset and related goodwill. If the events or circumstances indicate that the remaining balance of the intangible asset and goodwill may be permanently impaired, the potential impairment will be measured based upon the difference between the carrying amount of the intangible asset and goodwill and the fair value of such asset determined using the estimated future discounted cash flows (excluding interest charges) generated from the use and ultimate disposition of the respective acquired entity. Our management must make assumptions and estimates, such as the discount factor, in determining the estimated fair values. While we believe these assumptions and estimates are appropriate, other assumptions and estimates could be applied and might produce significantly different results.

Effective January 1, 2002, we ceased to amortize goodwill in accordance with SFAS No. 142, Goodwill and Other Intangible Assets. Goodwill is reviewed at least annually for impairment. In addition, we will perform an impairment analysis of intangible assets more frequently based on other factors. These factors would include significant changes in membership, state funding, medical contracts and provider networks and contracts. We did not recognize any impairment losses during the six months ended June 30, 2003 or the years ended December 31, 2002, 2001 or 2000.

Results of Operations

Six Months Ended June 30, 2003 Compared to Six Months Ended June 30, 2002

Revenues

Premiums for the six months ended June 30, 2003 increased $156.0 million, or 76.8%, to $359.1 million from $203.2 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 SCHIP contracts and the acquisition of 80% of the outstanding capital stock of UHP. In addition, we received weighted average rate increases effective January 1, 2003 of 1.0% in Indiana and 4.3% in Wisconsin.

Services revenues for the six months ended June 30, 2003 increased $4.3 million to $4.6 million from $211,000 for the comparable period in 2002. This increase resulted from increases in our non-risk SSI membership in our Texas market and services revenues of GPA since March 1, 2003.

Operating Expenses

Medical costs for the six months ended June 30, 2003 increased $132.3 million, or 79.2%, to $299.3 million from $167.1 million for the comparable period in 2002. This increase primarily reflected the growth in our membership as described above.

Cost of services for the six months ended June 30, 2003 increased $3.4 million to $3.6 million from $168,000 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 six months ended June 30, 2003 increased $18.1 million, or 81.8%, to $40.3 million from $22.2 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.

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Other Income (Expense)

Other income (expense) for the six months ended June 30, 2003 increased $320,000, or 17.0%, to $2.2 million from $1.9 million for the comparable period in 2002. This increase was due to a larger amount of dollars invested.

Income Tax Expense

For the six months ended June 30, 2003, we recorded income tax expense of $8.7 million based on a 38.3% effective tax rate. For the six months ended June 30, 2002, we recorded income tax expense of $6.3 million based on an effective tax rate of 39.9%. Our effective tax rate decreased period over period due to our investment in tax-advantaged securities and our implementation of state tax savings strategies.

Year Ended December 31, 2002 Compared to Year Ended December 31, 2001

Revenues

Premiums for the year ended December 31, 2002 increased $134.8 million, or 41.3%, to $461.0 million from $326.2 million in 2001. This increase was due to organic growth in our existing markets, the purchase of the Texas SCHIP contracts and the inclusion of one month of revenues of UHP. In addition, we received premium rate increases ranging from 1.5% to 10.7%, or 5.1% on a composite basis across our markets.

Services revenues for the year ended December 31, 2002 increased $72,000, or 18.7%, to $457,000 from $385,000 in 2001. This increase resulted from increases in our non-risk SSI membership in our Texas market.

Operating Expenses

Medical costs for the year ended December 31, 2002 increased $109.3 million, or 40.5%, to $379.5 million from $270.2 million in 2001. This increase reflected the growth in our membership.

Cost of services for the year ended December 31, 2002 increased $12,000, or 3.6%, to $341,000 from $329,000 for the comparable period in 2001. While the non-risk SSI membership increased between periods, the cost of services remained relatively flat as we leveraged existing systems to support the increased membership.

General and administrative expenses for the year ended December 31, 2002 increased $12.4 million, or 33.1%, to $50.1 million from $37.6 million in 2001. This increase reflected a higher level of wages and related expenses for additional staff to support our membership growth.

Other Income

Other income for the year ended December 31, 2002 increased $6.0 million, or 168.1%, to $9.5 million from $3.6 million in 2001. A majority of the increase is due to the receipt of a one-time dividend of $5.1 million from a captive insurance company in which we maintained an investment. In addition, investment income increased due to a larger amount of dollars invested, and interest expense decreased year over year due to the repayment of our subordinated debt in December 2001.

Income Tax Expense

For the year ended December 31, 2002 we recorded income tax expense of $15.6 million, or an effective tax rate of 38.0%. This compares to $9.1 million, or an effective tax rate of 41.5%, for the year ended December 31, 2001. Our effective tax rate decreased year over year due to our investment in tax-advantaged securities and our implementation of state tax saving strategies during 2002.

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Year Ended December 31, 2001 Compared to Year Ended December 31, 2000

Revenues

Premiums for the year ended December 31, 2001 increased $109.8 million, or 50.7%, to $326.2 million from $216.4 million in 2000. This increase was due to the Humana contract purchases, the consolidation of our El Paso market and membership growth, net of the termination of our Indiana sub-contract arrangement.

Services revenues for the year ended December 31, 2001 decreased $4.6 million, or 92.2%, to $385,000 from $4.9 million in 2000 as a result of our acquisition of a majority share of Superior HealthPlan, as described above.

Operating Expenses

Medical costs for the year ended December 31, 2001 increased $87.7 million, or 48.0%, to $270.2 million from $182.5 million in 2000. This increase was due to the Humana contract purchases, the consolidation of our El Paso market and membership growth, net of the termination of our Indiana sub-contract arrangement.

Cost of services for the year ended December 31, 2001 increased $194,000, or 143.7%, to $329,000 from $135,000 in 2000. This increase reflected the growth in the Texas non-risk SSI membership.

General and administrative expenses for the year ended December 31, 2001 increased $5.4 million, or 16.8%, to $37.6 million from $32.2 million in 2000. This increase primarily was due to a higher level of wages and related expenses for additional staff to support our membership growth.

Other Income

Other income for the year ended December 31, 2001 increased $2.9 million, or 434.4%, to $3.6 million from $665,000 in 2000. This primarily reflected a significant increase in investment income due to an increase in cash, cash equivalents and investments. The increase also reflected the consolidation of our El Paso market due to our increased ownership.

Income Tax Expense

For the year ended December 31, 2001, we recorded income tax expense of $9.1 million based on a 41.5% effective tax rate. For the year ended December 31, 2000, we recorded an income tax benefit of $543,000 primarily as a result of the reversal of our valuation allowance related to deferred tax assets.

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Quarterly Results

The following table sets forth unaudited consolidated statements of earnings data for the first two quarters of 2003 and for each quarter of 2002 and 2001. This information has been presented on the same basis as our audited consolidated financial statements included elsewhere in this prospectus and, in the opinion of management, includes all adjustments, consisting only of normal recurring adjustments, necessary to present fairly the quarterly results. This information should be read in conjunction with our audited consolidated financial statements and related notes included elsewhere in this prospectus. The operating results for any quarter are not necessarily indicative of operating results to be expected for any future period.

	Three Months Ended									
	June 30, 2003	March 31, 2003	December 31, 2002	September 30, 2002	June 30, 2002	March 31, 2002	December 31, 2001	September 30, 2001	June 30, 2001	March 31, 2001
	(dollars in thousands, except per share data)									
Total revenues	$186,232	$177,434	$141,726	$116,398	$107,610	$ 95,753	$ 90,291	$ 85,414	$ 80,560	$ 70,304
Earnings from operations	10,336	10,147	9,598	8,028	7,718	6,262	5,698	5,355	4,513	2,906
Earnings before income taxes	11,589	11,094	10,496	14,780	8,683	7,177	6,731	6,175	5,343	3,777
Net earnings	7,708	7,161	6,814	9,273	5,234	4,300	3,920	3,563	3,230	2,182
Net earnings attributable to common stockholders	7,708	7,161	6,814	9,273	5,234	4,300	3,822	3,440	3,107	2,059
Per share data:										
Net earnings per common share, basic	$ 0.47	$ 0.44	$ 0.42	$ 0.58	$ 0.34	$ 0.28	$ 0.91	$ 2.52	$ 2.27	$ 1.51
Net earnings per common share, diluted	0.43	$ 0.40	$ 0.38	$ 0.52	$ 0.30	$ 0.25	$ 0.30	$ 0.30	$ 0.28	$ 0.19
Period end membership	438,700	419,300	409,600	296,100	278,600	249,300	235,100	224,800	213,200	205,000

Liquidity and Capital Resources

On May 22, 2002, we closed a follow-on public offering of 7,500,000 shares of common stock at $16.50 per share. Of the 7,500,000 shares, 6,900,000 shares were offered by selling stockholders and 600,000 by us. On June 5, 2002, the underwriters of our follow-on public offering exercised their over-allotment option to purchase 1,019,258 additional shares from selling stockholders and 103,743 shares from us. We received net proceeds of $10.3 million from the two closings of the follow-on offering.

On December 18, 2001, we closed our initial public offering of 4,875,000 shares of common stock at $9.33 per share. We received net proceeds of $41.0 million. Prior to this offering, we financed our operations and growth through private equity and debt financings and internally generated funds, raising $22.4 million between 1993 and 1998. This consisted of $18.4 million through the issuance of equity securities and $4.0 million through subordinated debt financing.

Our operating activities provided cash of $9.4 million for the six months ended June 30, 2003 compared to $8.9 million for the six months ended June 30, 2002. This increase was due to continued profitability, and an increase for membership, partially offset by a decrease in medical claims liabilities and payment of accrued income taxes. Our operating activities provided cash of $39.7 million for 2002, $30.2 million for 2001 and $13.5 million for 2000. The increases in 2002 and 2001 were due to further improved profitability, increases in membership and the timing of premium payments.

Our investing activities used cash of $25.0 million for the six months ended June 30, 2003 and $63.9 million for the comparable period in 2002. Our investing activities used cash of $79.7 million in 2002, provided cash of $2.7 million in 2001 and used cash of $14.6 million in 2000. 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 June 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

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our subsidiaries may invest their cash. The average annualized portfolio yield was 5.5% for the six months ended June 30, 2003, 6.9% for 2002 (exclusive of a one-time dividend of $5.1 million from a captive insurance company in which we maintained an investment) and 5.6% for 2001. Our yield decreased due to our investment in tax-advantaged securities in the first quarter of 2003 and the third and fourth quarters of 2002, as well as a decrease in the overall interest rate environment.

Our financing activities used cash of $670,000 for the six months ended June 30, 2003 and provided cash of $10.4 million for the six months ended June 30, 2002. The use of cash for the six months ended June 30, 2003 was due to the elimination of liabilities acquired as part of the GPA acquisition, partially offset by proceeds from the exercise of stock options. Cash provided by financing activities for the six months ended June 30, 2002 was primarily due to the proceeds from the issuance of common stock through the follow-on public offering completed in May 2002. Our financing activities provided cash of $10.8 million in 2002 and $37.0 million in 2001 and used cash of $2.4 million in 2000. During 2002, financing cash flows primarily consisted of the issuance of common stock through our follow-on offering, the exercise of the over-allotment and proceeds received from the exercise of stock options. During 2001, financing cash flows primarily consisted of the issuance of common stock through our initial public offering net of the repayment of subordinated notes with $4.0 million of our proceeds. During 2000, financing cash flows consisted of borrowings and repayments under a credit facility and issuances of preferred stock.

We may use our existing funds, including proceeds from the offering made by this prospectus and our two earlier public offerings, to make strategic acquisitions including Medicaid and SCHIP businesses, specialty services businesses and contract rights to increase our membership and to expand our business into new service areas. In June 2003 we announced our agreement to purchase the Medicaid-related contract rights of HMO Blue Texas. This transaction includes the right to serve an additional 21,000 Medicaid lives and is expected to close in the third quarter of 2003. Effective March 1, 2003, we acquired a 63.7% interest in GPA for $4.3 million and purchased assets of ScriptAssist for $561,000. In 2002, we purchased the capital stock of Bankers Reserve Life Insurance Company of Wisconsin for $479,000, net of assets and liabilities acquired, and the rights to Texas Universities Health Plan s SCHIP contracts for $595,000. In addition, we purchased 80% of the outstanding capital stock of UHP for $10.6 million. In 2001, we purchased the rights to the Humana Medicaid contracts with the states of Texas and Wisconsin for $1.2 million.

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 $2.6 million of capital assets during the six months ended June 30, 2003, and we anticipate spending $5.1 million for additional capital expenditures during the remainder of 2003 on office and market expansions and system upgrades. In 2002, we spent $3.9 million on capital assets consisting primarily of new software, software and hardware upgrades, furniture, equipment and leasehold improvements related to office and market expansions. In 2001, we purchased $3.6 million of furniture, equipment and leasehold improvements due to the addition of the Austin and San Antonio markets and the expansion of the Wisconsin market.

In July 2003, we purchased the building in which our corporate headquarters in Saint Louis, Missouri are located for an aggregate purchase price of $12.5 million. We paid the purchase price in cash, and we currently are negotiating with a bank to borrow $8.0 million under a non-recourse mortgage loan arrangement to replenish a portion of the cash purchase price.

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

	Payments Due
July 1, 2003 through December 31, 2003	$ 2,774
2004	5,309
2005	4,707
2006	4,102
2007	3,520
Thereafter	14,166
Total	$34,578

In addition, we will acquire the remaining equity of UHP by no later than December 1, 2005, as described under Overview above.

In May 2002, we entered into a $25 million revolving line of credit facility with LaSalle Bank N.A. The facility had an initial term of one year, which we extended for an additional year effective in May 2003. The facility has interest rates based on LaSalle s prime rate and LIBOR. 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 any proposed acquisition that would result in a violation of any of the covenants contained in the facility. As of June 30, 2003, we were in compliance with all covenants and no funds had been drawn on the facility.

At June 30, 2003, we had working capital, defined as current assets less current liabilities, of $(19.1) 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 $52.8 million at June 30, 2003 and $69.2 million at December 31, 2002. Long-term investments were $116.6 million at June 30, 2003 and $95.4 million at December 31, 2002, including restricted deposits of $20.1 million at June 30, 2003 and $15.8 million at December 31, 2002. Cash and investments held by our unregulated entities totaled $41.5 million at June 30, 2003. Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations, cash available under our credit facility and the net proceeds of the offering made by this prospectus will be sufficient to finance our operations and capital expenditures for at least 12 months after the completion of the offering made by this prospectus.

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 June 30, 2003, our subsidiaries had aggregate statutory capital and surplus of $50.2 million, compared with the required minimum aggregate statutory capital and surplus requirements of $25.8 million. As of December 31, 2002, our subsidiaries had aggregate

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statutory capital and surplus of $36.9 million, compared with the required minimum aggregate statutory capital and surplus requirements of $22.0 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 plans in New Jersey. We continue to monitor the 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 Emerging Issues Task Force 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. We have adopted the disclosure requirements of FIN 45 as required for fiscal years ending after December 15, 2002 and have adopted the provisions for initial recognition and measurement for all guarantees issued or modified after December 31, 2002. The adoption of FIN 45 did not have a significant impact on our net income or equity. We have completed an inventory of potential contingencies and noted one potential guarantee that requires the following disclosure in our financial statement footnotes per FIN 45:

Within the Company s Medicaid contract with the state of Wisconsin, the Company is required to pay a fee if its contracted physicians do not provide an adequate number of healthy examinations to certain member groups. This agreement constitutes a performance guarantee. At the end of each fiscal year, the Company performs an analysis to estimate the amount owed to the state of Wisconsin, if any, under the performance guarantees. The state of Wisconsin, however, does not calculate or request payment for the

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amount owed until at least thirteen months subsequent to each year end. As such, the Company has recorded a current payable for any portions owed within one year and a long-term liability for portions owed for a period greater than one year from the balance sheet date. As of December 31, 2002 and 2001, the Company recorded $2.0 million and $829,000, respectively, of accounts payable and other accrued expenses for the current portions of the fees owned and $1.0 million at both year ends of other long-term liabilities for the long-term portions.

We have guaranteed that one of our managed care subsidiaries will 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. The capital of this subsidiary exceeded the amount required at June 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 June 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 June 30, 2003. We do not expect that adoption of SFAS No. 149 will have a material impact on our financial statements.

Quantitative and Qualitative Disclosures About Market Risk

As of June 30, 2003, we had short-term investments of $9.4 million and long-term investments of $116.6 million, including restricted deposits of $20.1 million. The short-term investments consisted of highly liquid securities with maturities between three and 12 months. The long-term investments consisted of municipal bonds and instruments of U.S. government-backed agencies and the U.S. Treasury, and have 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 state s requirements. These investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold these short-term investments to maturity, and as a result, we would not expect the value of these investments to decline significantly as a result of a sudden change in market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at June 30, 2003, the fair value of our fixed income investments would have decreased by approximately $2.9 million. Similarly, a 1% decrease in market interest

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rates at June 30, 2003 would have resulted in an increase of the fair value of our investments of approximately $2.9 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 though 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 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 $179,000 in the six months ended June 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.

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BUSINESS

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. We believe our local approach to managing our health plans, including provider and member services, enables us to provide accessible, high quality, culturally-sensitive healthcare services to our members. Our disease management, educational and other initiatives are designed to help members best utilize the healthcare system to ensure they receive appropriate, medically necessary services and effective management of routine health problems, as well as more severe acute and chronic conditions. We combine our decentralized local approach with centralized finance, information systems, claims processing and medical management support functions.

Our Approach

Our approach to managed care is based on the following key attributes:

Medicaid Expertise. Over the last 19 years, we have developed a specialized Medicaid expertise that has helped us establish and maintain strong relationships with our constituent communities of members, providers and state governments. We have implemented programs developed to achieve savings for state governments and improve medical outcomes for members by reducing inappropriate emergency room use, inpatient days and high cost interventions, as well as by managing care of chronic illnesses. We do this primarily by providing nurse case managers who support our physicians in implementing disease management programs and by providing incentives for our physicians to provide preventive care on a regular basis. We recruit and train staff and providers who are attentive to the needs of our members and who are experienced in working with culturally diverse, low-income Medicaid populations. Our experience in working with state regulators helps us to implement and deliver our programs and services efficiently and affords us opportunities to provide input on Medicaid industry practices and policies in the states in which we operate.

Localized Services, Support and Branding. We provide access to healthcare services through local networks of providers and staff that focus on the cultural norms of their individual communities. Our systems and procedures have been designed to address these community-specific challenges through outreach, education, transportation and other member support activities. For example, our community outreach program employs several former Medicaid recipients to work with our members and their communities to promote health, and to promote self-improvement through employment and education. We use locally recognized plan names, and we tailor our materials and processes to meet the needs of the communities and the state programs we serve. Our approach to community-based service results in local accountability and solidifies our decentralized management and operational structure.

Collaborative Approach with States. Our approach is to work with state agencies on redefining benefit levels, eligibility requirements and provider fee schedules in order to maximize the number of uninsured individuals covered through Medicaid and SCHIP while maintaining adequate levels of provider compensation.

Physician-Driven Approach. We have implemented a physician-driven approach in which our physicians are actively engaged in developing and implementing our healthcare delivery policies and strategies. Our local boards of directors, which help shape the character and quality of our organization, have significant provider representation in each of our principal geographic markets. This approach is designed to eliminate unnecessary costs, improve service to our members and simplify the administrative burdens on our providers. It has enabled us to strengthen our provider networks through improved physician recruitment and retention that, in turn, have helped to increase our membership base.

Efficiency of Business Model. We have designed our business model to allow us to readily add new members in our existing markets and expand into new regions in which we may choose to operate. The combination of our decentralized local approach to operating our health plans and our centralized