CENTENE CORP
Form 10-Q
October 23, 2007

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

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

For the quarterly period ended September 30, 2007

OR

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

For the transition period from to

Commission file number 000-33395

CENTENE CORPORATION

(Exact name of registrant as specified in its charter)

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

Registrant's telephone number, including area code:

(314) 725-4477

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of

the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days: [X] Yes [ ] No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of “accelerated filer and large accelerated filer” in Rule 12b-2 of the Exchange Act.
Large accelerated filer [X] Accelerated filer [ ] Non-accelerated filer [ ]

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

As of October 15, 2007, the registrant had 43,526,414 shares of common stock outstanding.

CENTENE CORPORATION

QUARTERLY REPORT ON FORM 10-Q

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PART I

FINANCIAL INFORMATION

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

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS
(In thousands, except share data)

	September 30, 2007	December 31, 2006
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 275,048	$ 271,047
Premium and related receivables	84,813	91,664
Short-term investments, at fair value (amortized cost $48,312 and $67,199, respectively)	48,095	66,921
Other current assets	42,496	22,189
Total current assets	450,452	451,821
Long-term investments, at fair value (amortized cost $288,732 and $146,980, respectively)	289,608	145,417
Restricted deposits, at fair value (amortized cost $26,667 and $25,422, respectively)	26,804	25,265
Property, software and equipment, net	139,671	110,688
Goodwill	133,151	135,877
Other intangible assets, net	13,829	16,202
Other assets	32,725	9,710
Total assets	$ 1,086,240	$ 894,980
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liabilities	$ 316,617	$ 280,441
Accounts payable and accrued expenses	102,728	72,723
Unearned revenue	44,496	33,816
Current portion of long-term debt	998	971
Total current liabilities	464,839	387,951
Long-term debt	201,140	174,646
Other liabilities	11,712	5,960
Total liabilities	677,691	568,557
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; issued and outstanding 43,496,447 and 43,369,918 shares, respectively	44	44
Additional paid-in capital	217,746	209,340
Accumulated other comprehensive income:		
Unrealized gain (loss) on investments, net of tax	493	(1,251)

Retained earnings	190,266	118,290
Total stockholders' equity	408,549	326,423
Total liabilities and stockholders' equity	$ 1,086,240	$ 894,980

See notes to consolidated financial statements.

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CENTENE CORPORATION AND SUBSIDIARIES

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2007	2006	2007	2006
	(Unaudited)		(Unaudited)	
Revenues:				
Premium	$ 730,253	$ 610,661	$ 2,087,219	$ 1,522,302
Service	19,696	20,588	61,303	59,318
Total revenues	749,949	631,249	2,148,522	1,581,620
Expenses:				
Medical costs	592,128	501,350	1,702,396	1,263,251
Cost of services	13,622	15,373	45,922	45,278
General and administrative expenses	121,139	99,984	350,601	239,647
Impairment loss	—	81,098	—	81,098
Gain on sale of FirstGuard Missouri	—	—	(7,472)	—
Total operating expenses	726,889	697,805	2,091,447	1,629,274
Earnings (loss) from operations	23,060	(66,556)	57,075	(47,654)
Other income (expense):				
Investment and other income	6,352	4,625	16,801	12,056
Interest expense	(4,171)	(3,082)	(11,516)	(7,536)
Earnings (loss) before income taxes	25,241	(65,013)	62,360	(43,134)
Income tax expense (benefit)	9,305	6,180	(9,569)	14,328
Net earnings (loss)	$ 15,936	$ (71,193)	$ 71,929	$ (57,462)
Earnings per share:				
Basic earnings (loss) per common share	$ 0.37	$ (1.65)	$ 1.65	$ (1.33)
Diluted earnings (loss) per common share	$ 0.36	$ (1.65)	$ 1.61	$ (1.33)
Weighted average number of shares outstanding:				
Basic	43,532,832	43,219,053	43,528,201	43,126,062
Diluted	44,628,560	43,219,053	44,787,981	43,126,062

See notes to consolidated financial statements.

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CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)

	Nine Months Ended September 30,	
	2007	**2006**
	(Unaudited)	
Cash flows from operating activities:		
Net earnings (loss)	$ 71,929	$ (57,462)
Adjustments to reconcile net earnings (loss) to net cash provided by operating activities —		
Depreciation and amortization	20,381	15,286
Stock compensation expense	11,753	11,168
Impairment loss	—	87,091
Deferred income taxes	(859)	(4,493)
Gain on sale of FirstGuard Missouri	(7,472)	—
Changes in assets and liabilities —		
Premium and related receivables	6,855	(34,209)
Other current assets	(15,540)	2,705
Other assets	(934)	(455)
Medical claims liabilities	36,312	74,367
Unearned revenue	10,680	4,816
Accounts payable and accrued expenses	27,981	25,929
Other operating activities	3,666	(188)
Net cash provided by operating activities	164,752	124,555
Cash flows from investing activities:		
Purchases of property, software and equipment	(41,774)	(39,494)
Purchases of investments	(464,378)	(235,501)
Sales and maturities of investments	341,450	200,155
Proceeds from asset sales	14,102	—
Investments in acquisitions and equity method investee, net of cash acquired	(26,425)	(66,921)
Net cash used in investing activities	(177,025)	(141,761)
Cash flows from financing activities:		
Proceeds from exercise of stock options	3,737	4,594
Proceeds from borrowings	202,000	83,359
Payment of long-term debt	(176,729)	(12,505)
Excess tax benefits from stock compensation	1,028	2,094
Common stock repurchases	(8,581)	(7,214)
Debt issue costs	(5,181)	—
Net cash provided by financing activities	16,274	70,328
Net increase in cash and cash equivalents	4,001	53,122
Cash and cash equivalents, beginning of period	271,047	147,358
Cash and cash equivalents, end of period	$ 275,048	$ 200,480
Interest paid	$ 4,480	$ 7,582
Income taxes paid	$ 6,965	$ 5,223

See notes to consolidated financial statements.

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CENTENE CORPORATION AND SUBSIDIARIES

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

1. Organization and Operations

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

2. Basis of Presentation

The unaudited interim financial statements herein have been prepared by the Company pursuant to the rules and regulations of the Securities and Exchange Commission. The accompanying interim financial statements have been prepared under the presumption that users of the interim financial information have either read or have access to the audited financial statements for the fiscal year ended December 31, 2006. Accordingly, footnote disclosures, which would substantially duplicate the disclosures contained in the December 31, 2006 audited financial statements, have been omitted from these interim financial statements where appropriate. In the opinion of management, these financial statements reflect all adjustments, consisting only of normal recurring adjustments, which are necessary for a fair presentation of the results of the interim periods presented.

Certain 2006 amounts in the consolidated financial statements have been reclassified to conform to the 2007 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

3. Recent Accounting Pronouncements

In June 2006, the FASB ratified the consensus reached on Emerging Issues Task Force, or EITF, Issue No. 06-3, "How Sales Taxes Collected from Customers and Remitted to Governmental Authorities Should Be Presented in the Income Statement (That is, Gross Versus Net Presentation)", or EITF 06-3. The EITF reached a consensus that the presentation of taxes on either a gross or net basis is an accounting policy decision. The Company is evaluating the provisions of EITF 06-3 as it applies to premium taxes. Premium taxes are assessed by certain states as a percentage of premiums paid to the Company by those states. Premium taxes of $58,827 and $25,011 for the nine months ended September 30, 2007 and 2006, respectively, were reported as a component of revenues and general and administrative expenses, or on a gross basis. Effective with the reporting of our results for the fourth quarter of 2007, the Company intends to separately report premium taxes on the face of the statement of operations as a component of both revenues and operating expenses.

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

of the federal benefit on state issues) would decrease income tax expense, if recognized, and the remainder would reduce goodwill. Most of the amount that would reduce income tax expense, if recognized, relates to an audit in process and is expected to be resolved within the next twelve months.

The Company recognizes interest accrued related to unrecognized tax benefits in the provision for income taxes. As of January 1, 2007, interest accrued was approximately $293, net of federal tax benefit. No penalties have been accrued. Additional interest accrued was $29 and $107 in the three and nine months ended September 30, 2007, respectively.

During the first quarter of 2007, the Company's liability for unrecognized tax benefits increased by $1,563, of which the entire amount would reduce income tax expense if recognized. The increase was related to the allocation of stock basis between FirstGuard Kansas and FirstGuard Missouri for purposes of an Internal Revenue Code, or IRC, Section 165 loss on the Company's investment in FirstGuard Kansas' stock to be recognized in the Company's 2007 federal and state returns. During the second quarter of 2007, the Company also recorded an IRC Section 165 loss for the Company’s investment in FirstGuard Missouri stock and, accordingly, reversed the $1,563 unrecognized tax benefit as a reduction of income tax expense because the stock basis allocation was no longer relevant.

The Company's federal income tax returns for 2004 through 2006 are open tax years. The Company files in numerous state jurisdictions with varying statutes of limitation. The Company's unrecognized state tax benefits are related to state returns open from 2002 through 2006.

4. FirstGuard Health Plans

In 2006, FirstGuard Health Plan Kansas, Inc., or FirstGuard Kansas, a wholly owned subsidiary, received notification that its Medicaid contract scheduled to terminate December 31, 2006 would not be renewed. In 2006, the Company also evaluated its strategic alternatives for its Missouri subsidiary, FirstGuard Health Plan, Inc., or FirstGuard Missouri, and decided to divest the business.

The sale of the operating assets of FirstGuard Missouri was completed effective February 1, 2007 and the Company received a final contingent payment in the second quarter of 2007 resulting in a total gain on the sale of $7,472 in 2007. Goodwill associated with FirstGuard written off as part of the transaction was $5,995.

In March 2007, the Company abandoned the stock of FirstGuard Kansas to an unrelated entity. As a result of that abandonment, the Company recognized expense of $1,602 for the write-off of the remaining assets in that entity. The Company also recognized a $31,482 tax benefit for the tax deduction associated with the basis of that stock ($29,919 in the first quarter and $1,563 in the second quarter). The asset write-off is recorded in investment and other income. The income tax receivable associated with the tax deduction is recorded as a component of other current assets.

In June 2007, the Company abandoned the stock of FirstGuard Missouri to an unrelated entity. As a result of that abandonment, the Company recognized expense of $696 for the write-off of the remaining assets in that entity and a $4,806 tax benefit for the tax deduction associated with the basis of that stock. The asset write-off is recorded in investment and other income. The income tax receivable associated with the tax deduction is recorded as a component of other current assets.

The Company has incurred $8,683 of FirstGuard exit costs consisting primarily of lease termination fees and employee severance costs. The exit costs included $6,202 incurred in 2006, of which $3,027 was accrued at December 31, 2006. During the nine months ended September 30, 2007, the Company incurred an additional $2,481 of exit costs and made payments of $5,134. At September 30, 2007, the remaining accrual for these costs was $374. The Company also contributed $3,000 of the sale proceeds received in the second quarter to its charitable foundation.

The Company continues to wind-down the operations of FirstGuard Kansas and Missouri, consisting principally of the payment of medical claims incurred in 2006. The Company expects to report its FirstGuard results as discontinued operations upon completion of substantially all of these claims payments.

5. Acquisitions

In July 2007, the Company acquired a 49% minority ownership interest in Access Health Solutions, LLC, or Access, a Medicaid managed care entity in Florida. Under the terms of the transaction, the Company has an option to acquire the remaining interest in Access at a future date. The Company accounts for its investment in Access using the equity method of accounting.

Effective April 20, 2007, the Company acquired PhyTrust of South Carolina, LLC, or PhyTrust, a physician-driven company providing service as a Medicaid Medical Home Network. The results of operations for PhyTrust are included in the consolidated financial statements since April 20, 2007. Pro forma disclosures related to the acquisition have been excluded as immaterial.

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6. Debt

In March 2007, the Company issued $175,000 aggregate principal amount of 7 ¼% Senior Notes due April 1, 2014, or the Notes. The Notes have been registered under the Securities Act of 1933, as amended, pursuant to a registration rights agreement with the initial purchasers. The indenture governing the Notes contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio. Interest is paid semi-annually beginning in October 2007.

At September 30, 2007, total debt outstanding was $202,138, including current maturities of $998. The total debt outstanding consisted of $175,000 under the Notes, $20,482 of debt secured by real estate and $6,656 of capital leases.

7. Earnings Per Share

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2007	2006	2007	2006
Net earnings (loss)	$ 15,936	$ (71,193)	$ 71,929	$ (57,462)
Shares used in computing per share amounts:				
Weighted average number of common shares outstanding	43,532,832	43,219,053	43,528,201	43,126,062
Common stock equivalents (as determined by applying the treasury stock method)	1,095,728	—	1,259,780	—
Weighted average number of common shares and potential dilutive common shares outstanding	44,628,560	43,219,053	44,787,981	43,126,062
Basic earnings (loss) per common share	$ 0.37	$ (1.65)	$ 1.65	$ (1.33)
Diluted earnings (loss) per common share	$ 0.36	$ (1.65)	$ 1.61	$ (1.33)

The calculation of diluted earnings per common share for the three and nine months ended September 30, 2007 excludes the impact of 2,576,042 and 2,571,841 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

8. Stockholders' Equity

In November 2005, the Company's board of directors adopted a stock repurchase program authorizing the Company to repurchase up to 4,000,000 shares of common stock from time to time on the open market or through privately negotiated transactions. In October 2007, the repurchase program was extended through October 31, 2008, but the Company reserves the right to suspend or discontinue the program at any time. During the nine months ended September 30, 2007, the Company repurchased 425,200 shares at an average price of $20.18 and an aggregate cost of $8,581.

9. Contingencies

During the 2007 second quarter, the Company's subsidiary, Peach State Health Plan, received notice from the Georgia Department of Community Health that it was levying a $3,700 fine for alleged violations of the prior authorization timeliness provisions contained in the Company's Medicaid contract with the state. The Company provided additional

clarifying information regarding the alleged violations through an appeal process and received notice of a reduced sanction in September 2007. The Company has accrued its estimate of the final amount to be settled.

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

10. Segment Information

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

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

Segment information for the three months ended September 30, 2007, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 687,801	$ 62,148	$ —	$ 749,949
Revenue from internal customers	19,841	105,225	(125,066)	—
Total revenue	$ 707,642	$ 167,373	$ (125,066)	$ 749,949
Earnings from operations	$ 15,574	$ 7,486	$ —	$ 23,060

Segment information for the three months ended September 30, 2006, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 581,371	$ 49,878	$ —	$ 631,249
Revenue from internal customers	24,511	73,620	(98,131)	—
Total revenue	$ 605,882	$ 123,498	$ (98,131)	$ 631,249
Earnings (loss) from operations	$ (69,008)	$ 2,452	$ —	$ (66,556)

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Segment information for the nine months ended September 30, 2007, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 1,966,129	$ 182,393	$ —	$ 2,148,522
Revenue from internal customers	58,427	310,727	(369,154)	—
Total revenue	$ 2,024,556	$ 493,120	$ (369,154)	$ 2,148,522
Earnings from operations	$ 38,736	$ 18,339	$ —	$ 57,075

Segment information for the nine months ended September 30, 2006, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 1,444,413	$ 137,207	$ —	$ 1,581,620
Revenue from internal customers	67,513	140,100	(207,613)	—
Total revenue	$ 1,511,926	$ 277,307	$ (207,613)	$ 1,581,620
Earnings (loss) from operations	$ (52,339)	$ 4,685	$ —	$ (47,654)

11. Comprehensive Earnings

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2007	2006	2007	2006
Net earnings (loss)	$ 15,936	$ (71,193)	$ 71,929	$ (57,462)
Reclassification adjustment, net of tax	1	8	105	71
Change in unrealized gain on investments, net of tax	1,538	912	1,639	327
Total comprehensive earnings (loss)	$ 17,475	$ (70,273)	$ 73,673	$ (57,064)

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

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing, and in our annual report on Form 10-K for the year ended December 31, 2006. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under "Item 1A. Risk Factors."

OVERVIEW

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

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

Our third quarter performance for 2007 is summarized as follows:

- Quarter-end Medicaid Managed Care membership of 1,137,300.
- Total revenues of $749.9 million, an 18.8% increase over the comparable period in 2006.
- Medicaid and SCHIP health benefits ratio, or HBR, of 79.0%, SSI HBR of 89.6%, Specialty Services HBR of 81.7%.
- Medicaid Managed Care general and administrative, or G&A, expense ratio of 13.6% and Specialty Services G&A ratio of 15.1%.
- Operating earnings of $23.1 million.
- Diluted earnings per share of $0.36.
- Operating cash flows of $104.9 million.

Over the last year, we have experienced revenue growth in our Medicaid Managed Care segment. The following new contracts contributed to our growth:

- In February 2007, we began managing care for SSI recipients in the San Antonio and Corpus Christi markets of Texas with 32,500 members at September 30, 2007.
- In January, February, March and April 2007, we began managing care for SSI members in the Northeast, Southwest, Northwest and East Central regions of Ohio, respectively, with 19,900 members at September 30, 2007.
- In July 2006, we entered seven new counties in the East Central market of Ohio, and in October 2006, we entered 17 new counties in the Northwest market of Ohio.
- In September 2006, we expanded operations in Texas to include Medicaid and SCHIP members in the Corpus Christi, Austin and Lubbock markets, with 27,300 members at September 30, 2007.

We have opportunities to expand our operations, through the following acquisitions and new contract awards:

-

In July 2007, we acquired a minority ownership interest in Access Health Solutions, LLC, or Access, providing managed care for Medicaid recipients in Florida, with 86,900 members at September 30, 2007.

- In April 2007, we acquired PhyTrust of South Carolina, LLC, or PhyTrust, a physician-driven company providing service as a Medicaid Medical Home Network. At September 30, 2007, our non-risk membership in South Carolina was 29,300 members. Additionally, we plan to begin participating in the rollout of the state's conversion to at-risk managed care in late 2007.
- During the first quarter of 2007, we finalized the contractual terms of the Comprehensive Health Care for Children in Foster Care program award with the Texas Health and Human Services Commission, or HHSC. This statewide program will provide managed care services to participants in the Texas Foster Care program. The State of Texas has announced that membership operations are expected to commence April 1, 2008.

The following new contract contributed to the growth in our Specialty Services segment:

- Effective October 1, 2006, we began performing under our contract with the Arizona Health Care Cost Containment System to provide long-term care services in the Maricopa, Yuma and LaPaz counties in Arizona.

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RESULTS OF OPERATIONS AND KEY METRICS

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

	Three Months Ended September 30,			Nine Months Ended September 30,		
	2007	2006	% Change 2006-2007	2007	2006	% Change 2006-2007
Premium revenue	$ 730.2	$ 610.6	19.6 %	$ 2,087.2	$ 1,522.3	37.1%
Service revenue	19.7	20.6	(4.3)%	61.3	59.3	3.3%
Total revenues	749.9	631.2	18.8 %	2,148.5	1,581.6	35.8%
Medical costs	592.1	501.3	18.1 %	1,702.4	1,263.3	34.8%
Cost of services	13.6	15.4	(11.4)%	45.9	45.3	1.4%
General and administrative expenses	121.1	100.0	21.2 %	350.6	239.7	46.3%
Impairment loss	—	81.1	%	—	81.1	%
Gain on sale of FirstGuard Missouri	—	—	%	(7.5)	—	%
Earnings (loss) from operations	23.1	(66.6)	%	57.1	(47.8)	%
Investment and other income, net	2.1	1.5	41.3 %	5.2	4.6	16.9%
Earnings (loss) before income taxes	25.2	(65.1)	%	62.3	(43.2)	%
Income tax (benefit) expense	9.3	6.1	50.6 %	(9.6)	14.3	%
Net earnings (loss)	$ 15.9	$ (71.2)	%	$ 71.9	$ (57.5)	%
Diluted earnings (loss) per common share	$ 0.36	$ (1.65)	%	$ 1.61	$ (1.33)	%

Revenues and Revenue Recognition

Our Medicaid Managed Care segment generates revenues primarily from premiums we receive from the states in which we operate health plans. We receive a fixed premium per member per month pursuant to our state contracts. We generally receive premium payments during the month we provide services and recognize premium revenue during the period in which we are obligated to provide services to our members. Some states enact premium taxes or similar assessments, collectively, premium taxes, and these taxes are recorded as a component of revenues and general and administrative expenses (gross). Premium taxes totaled $20.7 million and $58.8 million in the three and nine months ended September 30, 2007, respectively, compared to $13.8 million and $25.0 million for the comparable periods in 2006. Some contracts allow for additional premium related to certain supplemental services provided such as maternity deliveries. Revenues are recorded based on membership and eligibility data provided by the states, which may be adjusted by the states for updates to this data. These adjustments have been immaterial in relation to total revenue recorded and are reflected in the period known.

Our Specialty Services segment generates revenues under contracts with state programs, healthcare organizations, and other commercial organizations, as well as from our own subsidiaries on market-based terms. Revenues are recognized when the related services are provided or as ratably earned over the covered period of services.

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

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

1. Medicaid Managed Care segment growth

For the nine months ended September 30, 2007, segment revenue from external customers increased to $1,966.1 million from $1,444.4 million in the same prior year period. The increase is primarily due to nine months of Georgia operations in 2007, compared to four months in 2006, and a higher mix of SSI membership. The premium revenue for SSI members is higher than Medicaid / SCHIP members. For example, in Ohio, the per member per month, or pmpm, premium for SSI members averages approximately $1,100. In Texas, the SSI pmpm averages approximately $460. The pmpm revenue for our Medicaid / SCHIP members averages approximately $190. The revenue associated with our Kansas and Missouri health plans was $83.8 million and $237.4 million for the three and nine months ended September 30, 2006, respectively. The following table sets forth our membership by state in our Medicaid Managed Care segment:

	September 30,	
	2007	**2006**
Georgia	286,200	252,600
Indiana	156,300	198,100
New Jersey	58,300	59,100
Ohio	127,500	88,300
South Carolina	29,300	—
Texas	347,000	259,900
Wisconsin	132,700	167,100
Subtotal	1,137,300	1,025,100
Kansas and Missouri	—	144,600
Total	1,137,300	1,169,700

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

	September 30,	
	2007	**2006**
Medicaid	841,600	818,000
SCHIP	223,500	189,100
SSI	72,200	18,000
Subtotal	1,137,300	1,025,100
Kansas and Missouri Medicaid/SCHIP members	—	144,600

Total	1,137,300	1,169,700

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From September 30, 2006 to September 30, 2007, our membership declined primarily as a result of the conclusion of our operations in Kansas and Missouri, offset by increases in Georgia, Ohio, South Carolina and Texas. We increased our Medicaid membership in Ohio by adding members under our new contract in the Northwest region. We also increased our SSI membership in Ohio with the commencement of our new contract to serve Aged, Blind or Disabled members. In Texas, we increased our membership through new Medicaid, SCHIP and SSI contracts in the Corpus Christi, San Antonio, Austin, and Lubbock markets. Our membership decreased in Wisconsin because of more stringent state eligibility requirements for the Medicaid and SCHIP programs, eligibility administration issues and the termination of certain physician contracts associated with a high cost hospital system. Our membership decreased in Indiana primarily due to adjustments made to our provider network made in connection with our new state-wide contract as well as the termination of certain non-exclusive physician contracts. Our membership in South Carolina is currently on a non-risk basis. In Florida, Access serves 86,900 members on a non-risk basis.

2. Premium rate increases

During the nine months ended September 30, 2007, we received premium rate increases ranging from 1.9% to 10.1%, or 2.7% on a composite basis across our markets. Our Texas subsidiary received a rate increase of 13.0%, effective September 2007, of which 11.1% is a pass through to providers as part of a settlement between the state and certain types of providers. We consider the net increase, 1.9%, to be our effective rate increase.

3. Specialty Services segment growth

For the nine months ended September 30, 2007, segment revenue from external customers was $182.4 million compared to $137.2 million for the same prior year period. In July 2006, we began offering managed vision care through our acquisition of OptiCare. In October 2006, our subsidiary, Bridgeway Health Solutions, began performing under our long-term care contract in Arizona. The increase in segment revenue over 2006 was driven primarily by both OptiCare and Bridgeway. At September 30, 2007, our behavioral health company, Cenpatico, provided behavioral health services to 99,000 members in Arizona and 35,600 members in Kansas, compared to 94,500 members in Arizona and 37,500 members in Kansas at September 30, 2006.

Operating Expenses

Medical Costs

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

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2007	2006	2007	2006
Medicaid and SCHIP	79.0%	82.0%	80.5%	82.8%
SSI	89.6	84.1	88.2	86.2
Specialty Services	81.7	82.9	78.9	83.5

Our Medicaid and SCHIP HBR for the three and nine months ended September 30, 2007 were 79.0% and 80.5%, respectively, a decrease of 3.0% and 2.3% over 2006. The decrease is primarily attributable to increased premium yield and the effect of higher premium taxes combined with a moderating medical cost trend. Sequentially, our Medicaid and SCHIP HBR decreased from 80.6% in the 2007 second quarter to 79.0% because of higher premium yield combined with a continued moderate medical cost trend.

The increase in the SSI HBR for the three and nine months ended September 30, 2007 reflects the new business in our Ohio and Texas health plans, partially offset by the effect of higher premium taxes.

The decrease in our Specialty Services HBR for the three and nine months ended September 30, 2007 is caused by the diversification of business in that segment.

Cost of Services

Our cost of services expense includes the pharmaceutical costs associated with our pharmacy benefit manager's external revenues. Cost of services also includes all direct costs to support the functions responsible for generation of our services revenues. These expenses consist of the salaries and wages of the professionals and teachers who provide the services and expenses related to facilities and equipment used to provide services.

General and Administrative Expenses

Our general and administrative expenses, or G&A, primarily reflect wages and benefits, including stock compensation expense, and other administrative costs related to our health plans, specialty companies and centralized functions that support all of our business units. Our major centralized functions are finance, information systems and claims processing. Premium taxes are also classified as G&A expenses. G&A increased in the three months ended September 30, 2007 over the comparable period in 2006 primarily due to premium taxes as well as expenses for additional facilities and staff to support our growth. In the third quarter of 2006, in conjunction with the impairment analysis discussed below, an impairment loss of $6.0 million was recorded for FirstGuard identifiable intangible assets and was recorded as a general and administrative expense under the Medicaid Managed Care segment.

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2007	2006	2007	2006
Medicaid Managed Care	13.6%	13.1%	13.5%	12.5%

Specialty Services	15.1	17.0	15.5	18.3

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The increase in the Medicaid Managed Care G&A expense ratio for the three and nine months ended September 30, 2007 primarily reflects increased premium taxes. Premium taxes were $20.7 million and $58.8 million in the three and nine months ended September 30, 2007, respectively, compared to $13.8 million and $25.0 million, respectively, for the comparable periods in 2006. The increase for the three months ended September 30, 2007 also includes the effect of our start-up costs in South Carolina and for our Texas Foster Care product, offset by the effect of the 2006 third quarter FirstGuard impairment charge.

The decrease in the Specialty Services G&A ratio for the three and nine months ended September 30, 2007 primarily reflects the overall leveraging of expense over higher revenues with the additions of Bridgeway and OptiCare, and the growth of US Script's business since the acquisition in January 2006.

Impairment Loss

In August 2006, FirstGuard Health Plan Kansas, Inc., or FirstGuard Kansas, our wholly owned subsidiary, received notification from the Kansas Health Policy Authority that its Medicaid contract scheduled to terminate December 31, 2006 would not be renewed. As a result of the notification from the Kansas Health Policy Authority, we conducted an impairment analysis of the identifiable intangible assets and goodwill of the FirstGuard reporting unit, which encompassed both the FirstGuard Kansas and FirstGuard Missouri health plans. The fair value of the FirstGuard reporting unit was determined using discounted expected cash flows and estimated market value. The impairment analysis resulted in a goodwill impairment of $81.1 million recorded as impairment loss in the consolidated statement of operations in the third quarter of 2006. The goodwill impairment was not deductible for tax purposes; however, a tax benefit for the abandonment of the stock of FirstGuard was realized in 2007.

Gain on Sale of FirstGuard Missouri

The sale of the operating assets of FirstGuard Missouri was completed effective February 1, 2007. Under the terms of the asset sale agreement, we received an initial payment upon the sale of FirstGuard Missouri resulting in a gain of $4.2 million in the first quarter of 2007. We recognized additional gain related to a final contingent payment in the second quarter of 2007 of $3.3 million. The goodwill associated with FirstGuard written off in the first quarter of 2007 as part of the transaction was $6.0 million.

Other Income (Expense)

Other income (expense) consists principally of investment income from our cash and investments and interest expense on our debt. Investment and other income increased $1.7 million and $4.7 million in the three and nine months ended September 30, 2007, respectively, over the comparable periods in 2006. The increase was primarily a result of larger investment balances. The increase in the nine months ended September 30, 2007, was offset by $2.3 million in asset write-offs associated with the abandonment of the stock of our FirstGuard health plans. Interest expense increased $1.1 million and $4.0 million in the three and nine months ended September 30, 2007, respectively, primarily from increased debt.

Income Tax (Benefit) Expense

We recognized a tax benefit of $9.6 million for the nine months ended September 30, 2007, despite having $62.4 million of pre-tax income. The 2007 provision includes tax benefits related to the stock abandonment of our FirstGuard health plans as well as tax expense related to the gain on the sale of our FirstGuard Missouri health plan. Our effective tax rate for the 2007 nine month period is 37.5% excluding these transactions. We recognized $14.3 million of income tax expense for the nine months ended September 30, 2006 despite having a pre-tax loss of $43.1 million. The 2006 pre-tax loss included a non-deductible goodwill impairment charge. Our effective tax rate

for the 2006 nine month period was 38% excluding the effect of this charge.

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LIQUIDITY AND CAPITAL RESOURCES

We finance our activities primarily through operating cash flows and borrowings under our revolving credit facility. Our total operating activities provided cash of $164.8 million in the nine months ended September 2007 compared to $124.6 million in the comparable period in 2006. Medical claims liabilities increased $36.3 million in the first nine months of 2007 reflecting new business in Ohio and Texas, offset by the payment of Kansas and Missouri claims incurred in 2006. We expect that the tax benefit we recorded associated with the abandonment of the stock of our Kansas and Missouri health plans will result in reduced income tax payments totaling approximately $11.4 million over the next two quarters.

Our investing activities used cash of $177.0 million in the nine months ended September 30, 2007 compared to $141.8 million in the comparable period in 2006. Our investing activities in 2007 consisted primarily of additions to the investment portfolios of our regulated subsidiaries including transfers from cash and cash equivalents to long-term investments. During 2006, our investing activities primarily consisted of the acquisition of US Script. Our investing activities in 2006 also included additions to the investment portfolios of our regulated subsidiaries. Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets within our investment guidelines. Net cash provided by and used in investing activities will fluctuate from year to year due to the timing of investment purchases, sales and maturities. As of September 30, 2007, our investment portfolio consisted primarily of fixed-income securities with an average duration of 2.0 years. Cash is invested in investment vehicles such as municipal bonds, corporate bonds, insurance contracts, commercial paper, equity securities and instruments of the U.S. Treasury. The states in which we operate prescribe the types of instruments in which our regulated subsidiaries may invest their cash.

We spent $41.8 million and $39.5 million on capital assets in the nine months ended September 30, 2007 and 2006, respectively, consisting primarily of software and hardware upgrades, and furniture, equipment and leasehold improvements related to office and market expansions. We anticipate spending an additional $17 million on additional capital expenditures in 2007 primarily related to system upgrades and market expansions.

We have been pursuing a redevelopment project in the City of Clayton, Missouri to accommodate office expansion plans associated with future company growth. In July, 2007 we announced we would consider other alternatives due to our current inability to acquire all the real estate necessary for the project in Clayton. In September 2007, we announced the signing of a letter of intent to locate our corporate headquarters in downtown St. Louis, Missouri. We expect to be a joint venture partner in the entity that will develop the relevant properties and that the other partners will serve as project developers and coordinate the project financing.

Our financing activities provided cash of $16.3 million and $70.3 million in the nine months ended September 30, 2007 and 2006, respectively. During 2007, our financing activities primarily related to proceeds from issuance of $175 million in senior notes as discussed below. During 2006, our financing activities primarily related to proceeds from borrowings under our credit facility. These borrowings were used primarily for the acquisition of US Script.

At September 30, 2007, we had negative working capital, defined as current assets less current liabilities, of $(14.4) million, as compared to $63.9 million at December 31, 2006. Our working capital is 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. We manage our short-term and long-term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short-term requirements as needed.

Cash, cash equivalents and short-term investments were $323.1 million at September 30, 2007 and $338.0 million at December 31, 2006. Long-term investments were $316.4 million at September 30, 2007 and $170.7 million at December 31, 2006, including restricted deposits of $26.8 million and $25.3 million, respectively. At September 30,

2007, cash and investments held by our unregulated entities totaled $45.9 million while cash and investments held by our regulated entities totaled $593.6 million.

We have a $300 million revolving credit agreement. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. There is a commitment fee on the unused portion of the agreement that ranges from 0.15% to 0.275% depending on the total debt to EBITDA ratio. The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt to EBITDA ratios and minimum net worth. The agreement will expire in September 2011. As of September 30, 2007, we had no borrowings outstanding under the agreement and $24.5 million in letters of credit outstanding, leaving availability of $275.5 million. As of September 30, 2007, we were in compliance with all covenants.

In March 2007, we issued $175 million aggregate principal amount of our 7 ¼% Senior Notes due April 1, 2014. In July 2007, the Notes were registered under the Securities Act of 1933, pursuant to a registration rights agreement with the initial purchasers. The indenture governing the Notes contains non-financial and financial covenants, including requiring a minimum fixed charge coverage ratio. Interest is paid semi-annually beginning in October 2007. We used a portion of the net proceeds from the offering to refinance approximately $150.0 million of our existing indebtedness which was outstanding under our revolving credit facility. The additional proceeds will be used for general corporate purposes. As of September 30, 2007, we were in compliance with all covenants.

We have a stock repurchase program authorizing us to repurchase up to four million shares of common stock from time to time on the open market or through privately negotiated transactions. In October 2007, the repurchase program was extended through October 31, 2008, but we reserve the right to suspend or discontinue the program at any time. During the nine months ended September 30, 2007, we repurchased 425,200 shares at an average price of $20.18. We have established a trading plan with a registered broker to repurchase shares under certain market conditions.

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

During the nine months ended September 30, 2007, we received dividends of $35.4 million for the excess regulatory capital remaining in our Kansas and Missouri health plans and dividends of $14.5 million from other regulated subsidiaries.

There were no other material changes outside the ordinary course of business in lease obligations or other contractual obligations in the nine months ended September 30, 2007. Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our credit facility will be sufficient to finance our operations and capital expenditures for at least 12 months from the date of this filing.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

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

Our regulated subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of September 30, 2007, our subsidiaries had aggregate statutory capital and surplus of $286.8 million, compared with the required minimum aggregate statutory capital and

surplus requirements of $177.4 million.

The National Association of Insurance Commissioners has adopted rules which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of September 30, 2007, all of our health plans were in compliance with the risk-based capital requirements enacted in their respective states.

FORWARD-LOOKING STATEMENTS

All statements, other than statements of current or historical fact, contained in this filing are forward-looking statements. We have attempted to identify these statements by terminology including “believe,” “anticipate,” “plan,” “expect,” “estimate,” “intend,” “seek,” “target,” “goal,” “may,” “will,” “should,” “can,” “continue” and other similar words or expressions in connection with, among other things, any discussion of future operating or financial performance. In particular, these statements include statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, including those entitled “Management’s Discussion and Analysis of Financial Condition and Results of Operations,” Item 1. “Legal Proceedings” and Item 1A. “Risk Factors.” Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, including economic, regulatory, competitive and other factors that may cause our or our industry’s actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

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

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

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

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

INVESTMENTS

As of September 30, 2007, we had short-term investments of $48.1 million and long-term investments of $316.4 million, including restricted deposits of $26.8 million. The short-term investments consist of highly liquid securities with maturities between three and twelve months. The long-term investments consist of municipal, corporate and U.S. agency bonds, equity securities, asset-backed securities, life insurance contracts and U.S. Treasury investments and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states’ requirements, restricted deposits are classified as long-term regardless of the contractual maturity date. Our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at September 30, 2007, the fair value of our fixed income investments would decrease by approximately $5.1 million. Declines in interest rates over time will reduce our investment income.

INFLATION

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

While we currently believe our strategies to mitigate healthcare cost inflation will be successful, competitive pressures, new healthcare and pharmaceutical product introductions, demands from healthcare providers and

customers, applicable regulations or other factors may affect our ability to control the impact of healthcare cost increases.

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

Evaluation of Disclosure Controls and Procedures - Our management, with the participation of our chief executive officer and chief financial officer, evaluated the effectiveness of our disclosure controls and procedures as of September 30, 2007. The term “disclosure controls and procedures,” as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act, means controls and other procedures of a company that are designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the company’s management, including its principal executive and principal financial officers, as appropriate to allow timely decisions regarding required disclosure. Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving their objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Based on the evaluation of our disclosure controls and procedures as of September 30, 2007, our chief executive officer and chief financial officer concluded that, as of such date, our disclosure controls and procedures were effective at the reasonable assurance level.

Changes in Internal Control Over Financial Reporting - No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the quarter ended September 30, 2007 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

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PART II

OTHER INFORMATION

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

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

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

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

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

Risks Related to Being a Regulated Entity

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

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

For example, in August 2007, the Centers for Medicare & Medicaid Services, or CMS, published a final rule regarding the estimation and recovery of improper payments made under Medicaid and SCHIP. This rule requires a CMS contractor to sample selected states each year to estimate improper payments in Medicaid and SCHIP and create national and state specific error rates. States must provide information to measure improper payments in Medicaid and SCHIP for managed care and fee-for-service. Each state will be selected for review once every three years for each program. States are required to repay CMS the federal share of any overpayments identified.

On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 to reduce the size of the federal deficit. The Act reduces federal spending by nearly $40 billion over 5 years, including a $5 billion reduction in Medicaid. The Act reduces spending by cutting Medicaid payments for prescription drugs and gives states new power to reduce or reconfigure benefits. This law may also lead to lower Medicaid reimbursements in some states. The Bush administration's budget proposal for fiscal year 2008 proposes cutting Medicaid funding by $25.7 billion in funding reductions over five years. Additionally, the Bush administration's 2008 budget for SCHIP provides for yearly allotments at the fiscal year 2007 levels, plus an additional $5 billion over the five-year period, which some believe will result in a funding shortfall. States also periodically consider reducing or reallocating the amount of money they spend for Medicaid, SCHIP and SSI. In recent years, the majority of states have implemented measures to restrict

Medicaid, SCHIP and SSI costs and eligibility.

Changes to Medicaid, SCHIP and SSI programs could reduce the number of persons enrolled in or eligible for these programs, reduce the amount of reimbursement or payment levels, or increase our administrative or healthcare costs under those programs, all of which could have a negative impact on our business. We believe that reductions in Medicaid, SCHIP and SSI payments could substantially reduce our profitability. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds.

If SCHIP is not reauthorized, our business could suffer.

The authorization for SCHIP expired at the end of federal fiscal year 2007 (September 30, 2007). Congress has passed a continuing resolution that approved a six-week extension of SCHIP at 2007 funding levels. If SCHIP is not reauthorized by mid-November when the continuing resolution expires, we cannot predict whether another continuing resolution will be passed. Further, we cannot guarantee that federal funding of SCHIP will be reauthorized and if it is, what changes might be made to the program following reauthorization. President Bush and Congress have expressed differing views as to what should be contained in an SCHIP reauthorization bill. It is unclear how and when these differences will be resolved and therefore we cannot predict the impact that reauthorization will have on our business, assuming SCHIP is reauthorized.

Several states have faced shortfalls in federal SCHIP funding, which could have an impact on our business.

States receive matching funds from the federal government to pay for their SCHIP programs, which matching funds have a per state annual cap. It had been predicted that two states in which we have SCHIP contracts, Georgia and New Jersey, would spend all of their federal allocation for fiscal year 2007 prior to the end of the year. In December 2006, Congress passed legislation that redistributed funds that were not spent in prior years to the states that were facing these shortfalls. The Congressional Research Service estimated that this legislation would delay the shortfall to the first part of May 2007. On May 25, 2007, President Bush signed a bill that allocates $650 million to cover the SCHIP shortfalls. It therefore does not currently appear that any states in which we have SCHIP contracts will suffer a shortfall in fiscal year 2007. However, because they have funding caps, there is a risk that these states could experience shortfalls in future years, which could have an impact on our ability to receive amounts owed to us from these states.

If our Medicaid and SCHIP contracts are terminated or are not renewed, our business will suffer.

We provide managed care programs and selected services to individuals receiving benefits under federal assistance programs, including Medicaid, SCHIP and SSI. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. Our contracts with various states are generally intended to run for one or two years and may be extended for one or two additional years if the state or its agent elects to do so. Our current contracts are set to expire between December 31, 2007 and December 31, 2010. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. For example, on August 25, 2006, we received notification from the Kansas Health Policy Authority that FirstGuard Health Plan Kansas, Inc.'s contract with the State would not be renewed or extended, and as a result, our contract ended on December 31, 2006. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds. Our contracts could also be terminated if we fail to perform in accordance with the standards set by state regulatory agencies. For example, the Indiana contract under which we operate can be terminated by the State without cause. If any of our contracts are terminated, not renewed, or renewed on less favorable terms, our business will suffer, and our operating results may be materially affected.

Changes in government regulations designed to protect the financial interests of providers and members rather than our investors could force us to change how we operate and could harm our business.

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

- force us to restructure our relationships with providers within our network;
- require us to implement additional or different programs and systems;
- mandate minimum medical expense levels as a percentage of premium revenues;
- restrict revenue and enrollment growth;

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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 previously considered various forms of patient protection legislation commonly known as the Patients' Bill of Rights and such legislation may be proposed again. We cannot predict the impact of any such legislation, if adopted, on our business.

Regulations may decrease the profitability of our health plans.

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

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

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

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

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

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

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

unnecessary goods or services. HIPAA established new enforcement mechanisms to combat fraud and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of most individually identifiable health information. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules.

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

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

In addition, the Sarbanes-Oxley Act, as well as rules subsequently implemented by the SEC and the New York Stock Exchange, or the NYSE, have imposed various requirements on public companies, including requiring changes in corporate governance practices. Our management and other personnel will continue to devote time to these compliance initiatives.

The Sarbanes-Oxley Act requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on the effectiveness of our internal controls over our financial reporting as required by Section 404 of the Sarbanes-Oxley Act. Our testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 requires that we incur substantial accounting expense and expend significant management efforts. Moreover, if we are not able to comply with the requirements of Section 404, or if we or our independent registered public accounting firm identifies deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the NYSE, SEC or other regulatory authorities, which would require additional financial and management resources.

Changes in healthcare law and benefits may reduce our profitability.

Numerous proposals relating to changes in healthcare law have been introduced, some of which have been passed by Congress and the states in which we operate or may operate in the future. Changes in applicable laws and regulations are continually being considered, and interpretations of existing laws and rules may also change from time to time. We are unable to predict what regulatory changes may occur or what effect any particular change may have on our business. For example, these changes could reduce the number of persons enrolled or eligible to enroll in Medicaid, reduce the reimbursement or payment levels for medical services or reduce benefits included in Medicaid coverage. We are also unable to predict whether new laws or proposals will favor or hinder the growth of managed healthcare in general. Legislation or regulations that require us to change our current manner of operation, benefits provided or our contract arrangements may seriously harm our operations and financial results.

For example, in August 2007 CMS issued guidance that imposes new requirements on states that cover children in families with incomes above 250% of the federal poverty level. Under these new requirements, applicable states must provide assurances to CMS that the state has enrolled at least 95% of the Medicaid and SCHIP eligible children in the

state who are in families with incomes below 200% of the federal poverty level in Medicaid or SCHIP and that the number of children insured through private employers has not decreased by more than two percentage points over the prior five year period. Three states in which we have SCHIP contracts, Georgia, New Jersey and Wisconsin, are subject to these new regulations. If they are unable to meet these new requirements, they will be unable to continue to cover children in families with incomes above 250% of the federal poverty level, which would likely decrease our membership in such states. Many states object to these new requirements as unduly burdensome and likely to result in a decrease in the number of children covered by SCHIP, and some states, including New Jersey, are pursuing legal challenges against CMS in relation to these new requirements. CMS expects states to comply with the new requirements within 12 months of the issuance of the guidance. We cannot predict whether legal challenges to the new policy will be successful or whether the reauthorized version of SCHIP will expressly address these new requirements. We cannot predict the impact these requirements will have on our revenue if changes are implemented in states in which we serve SCHIP beneficiaries.

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If a state fails to renew a required federal waiver for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may administer Medicaid managed care programs pursuant to demonstration programs or required waivers of federal Medicaid standards. Waivers and demonstration programs are generally approved for two year periods and can be renewed on an ongoing basis if the state applies. We have no control over this renewal process. If a state does not renew such a waiver or demonstration program or the Federal government denies a state's application for renewal, membership in our health plan in the state could decrease and our business could suffer.

Changes in federal funding mechanisms may reduce our profitability.

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

On May 29, 2007, CMS issued a final rule that would reduce states' use of intergovernmental transfers for the states' share of Medicaid program funding. By restricting the use of intergovernmental transfers, this rule may restrict some states' funding for Medicaid, which could adversely affect our growth, operations and financial performance. On May 25, 2007, President Bush signed an Iraq war supplemental spending bill that includes a one-year moratorium on the effectiveness of the final rule. We cannot predict whether the rule will ever be implemented and if it is, what impact it will have on our business.

Recent legislative changes in the Medicare program may also affect our business. For example, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 revised cost-sharing requirements for some beneficiaries and requires states to reimburse the federal Medicare program for costs of prescription drug coverage provided to beneficiaries who are enrolled simultaneously in both the Medicaid and Medicare programs. The Bush administration has also proposed to further reduce total federal funding for the Medicaid program by $25.7 billion over the next five years. These changes may reduce the availability of funding for some states' Medicaid programs, which could adversely affect our growth, operations and financial performance. In addition, the new Medicare prescription drug benefit is interrupting the distribution of prescription drugs to many beneficiaries simultaneously enrolled in both Medicaid and Medicare, prompting several states to pay for prescription drugs on an unbudgeted, emergency basis without any assurance of receiving reimbursement from the federal Medicaid program. These expenses may cause some states to divert funds originally intended for other Medicaid services which could adversely affect our growth, operations and financial performance.

If state regulatory agencies require a statutory capital level higher than the state regulations, we may be required to make additional capital contributions.

Our operations are conducted through our wholly owned subsidiaries, which include health maintenance organizations, or HMOs, and managed care organizations, or MCOs. HMOs and MCOs are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Additionally, state regulatory agencies may require, at their discretion, individual HMOs to maintain statutory capital levels higher than the state regulations. If this were to occur to one of our subsidiaries, we may be required to make

additional capital contributions to the affected subsidiary. Any additional capital contribution made to one of the affected subsidiaries could have a material adverse effect on our liquidity and our ability to grow.

If we are unable to participate in SCHIP programs, our growth rate may be limited.

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

If state regulators do not approve payments of dividends and distributions by our subsidiaries to us, we may not have sufficient funds to implement our business strategy.

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

Risks Related to Our Business

Ineffectiveness of state-operated systems and subcontractors could adversely affect our business.

Our health plans rely on other state-operated systems or sub-contractors to qualify, solicit, educate and assign eligible clients into the health plans. The effectiveness of these state operations and sub-contractors can have a material effect on a health plan's enrollment in a particular month or over an extended period. When a state implements new programs to determine eligibility, new processes to assign or enroll eligible clients into health plans, or chooses new contractors, there is an increased potential for an unanticipated impact on the overall number of members assigned into the health plans.

Failure to accurately predict our medical expenses could negatively affect our reported results.

Our medical expenses include estimates of medical expenses incurred but not yet reported, or IBNR. We estimate our IBNR medical expenses monthly based on a number of factors. Adjustments, if necessary, are made to medical expenses in the period during which the actual claim costs are ultimately determined or when criteria used to estimate IBNR change. We cannot be sure that our IBNR estimates are adequate or that adjustments to those estimates will not harm our results of operations. For example, in the three months ended June 30, 2006 we adjusted our IBNR by $9.7 million for adverse medical cost development from the first quarter of 2006. In addition, when we commence operations in a new state or region, we have limited information with which to estimate our medical claims liabilities. For example, we commenced operations in the Atlanta and Central regions of Georgia on June 1, 2006 and the Southwest region of Georgia on September 1, 2006 and have based our estimates on state provided historical actuarial data and limited actual incurred and received data. From time to time in the past, our actual results have varied from our estimates, particularly in times of significant changes in the number of our members. Our failure to estimate IBNR accurately may also affect our ability to take timely corrective actions, further harming our results.

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

Our premium revenues consist of fixed monthly payments per member and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide healthcare services as established by the state governments. We use a large portion of our revenues to pay

the costs of healthcare services delivered to our members. If premiums do not increase when expenses related to medical services rise, our earnings will be affected negatively. In addition, our actual medical services costs may exceed our estimates, which would cause our health benefits ratio, or our expenses related to medical services as a percentage of premium revenue, to increase and our profits to decline. In addition, it is possible for a state to increase the rates payable to the hospitals without granting a corresponding increase in premiums to us. If this were to occur in one or more of the states in which we operate, our profitability would be harmed. In addition, if there is a significant delay in our receipt of premiums to offset previously incurred health benefits costs, our earnings could be negatively impacted.

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

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

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

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

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

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

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

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

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

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

Additionally, our growth strategy includes start-up operations in new markets or new products in existing markets. We may incur significant expenses prior to commencement of operations and the receipt of revenue. As a result, these start-up operations may decrease our profitability. In the event we pursue any opportunity to diversify our business internationally, we would become subject to additional risks, including, but not limited to, political risk, an unfamiliar

regulatory regime, currency exchange risk and exchange controls, cultural and language differences, foreign tax issues, and different labor laws and practices.

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

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

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

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

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

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

Operations in a few states have accounted for most of our premium revenues to date. For example, our Medicaid contract with Kansas, which terminated December 31, 2006, together with our Medicaid contract with Missouri accounted for $317.0 million in revenue for the year ended December 31, 2006. If we were unable to continue to operate in any of our current states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on legislative or other governmental or regulatory actions and decisions, economic conditions and similar factors in those states. Our inability to continue to operate in any of the states in which we operate would harm our business.

Competition may limit our ability to increase penetration of the markets that we serve.

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

Some of the health plans with which we compete have greater financial and other resources and offer a broader scope of products than we do. In addition, significant merger and acquisition activity has occurred in the managed care

industry, as well as in industries that act as suppliers to us, such as the hospital, physician, pharmaceutical, medical device and health information systems businesses. To the extent that competition intensifies in any market that we serve, our ability to retain or increase members and providers, or maintain or increase our revenue growth, pricing flexibility and control over medical cost trends may be adversely affected.

In addition, in order to increase our membership in the markets we currently serve, we believe that we must continue to develop and implement community-specific products, alliances with key providers and localized outreach and educational programs. If we are unable to develop and implement these initiatives, or if our competitors are more successful than we are in doing so, we may not be able to further penetrate our existing markets.

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If we are unable to maintain relationships with our provider networks, our profitability may be harmed.

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

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

We will be required to establish acceptable provider networks prior to entering new markets. We may be unable to enter into agreements with providers in new markets on a timely basis or under favorable terms. If we are unable to retain our current provider contracts or enter into new provider contracts timely or on favorable terms, our profitability will be harmed.

We may be unable to attract and retain key personnel.

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

Negative publicity regarding the managed care industry may harm our business and operating results.

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

Claims relating to medical malpractice could cause us to incur significant expenses.

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

attention. As a result, we may incur significant expenses and may be unable to operate our business effectively.

Loss of providers due to increased insurance costs could adversely affect our business.

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

Growth in the number of Medicaid-eligible persons during economic downturns could cause our operating results to suffer if state and federal budgets decrease or do not increase.

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

Growth in the number of Medicaid-eligible persons may be countercyclical, which could cause our operating results to suffer when general economic conditions are improving.

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

If we are unable to integrate and manage our information systems effectively, our operations could be disrupted.

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

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

We rely on the accuracy of eligibility lists provided by state governments. Inaccuracies in those lists would negatively affect our results of operations.

Premium payments to us are based upon eligibility lists produced by state governments. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we had made related payments to providers and were unable to recoup such payments from the providers.

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We may not be able to obtain or maintain adequate insurance.

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

From time to time, we may become involved in costly and time-consuming litigation and other regulatory proceedings, which require significant attention from our management.

We are a defendant from time to time in lawsuits and regulatory actions relating to our business. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and operating results. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and require significant attention from our management. For example, in 2006, we were named in two securities class action lawsuits that have now been dismissed. In addition, we may in the future be the target of similar litigation. As with other litigation, securities litigation could be costly and time consuming, require significant attention from our management and could harm our business and operating results.

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

Issuer Purchases of Equity Securities (1)
Third Quarter 2007

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs
July 1 – July 31, 2007	77,100	$ 21.25	77,100	3,374,900
August 1 – August 31, 2007	197,500	18.80	197,500	3,177,400
September 1 – September 30, 2007	—	—	—	3,177,400
TOTAL	274,600	$ 19.49	274,600	3,177,400

(1) On November 7, 2005 our Board of Directors adopted a stock repurchase program of up to 4,000,000 shares, which extends through October 31, 2008. During the three months ended September 30, 2007, we did not repurchase any shares other than through this publicly announced program.

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ITEM 6. ***Exhibits.***

Exhibits.

EXHIBIT NUMBER	DESCRIPTION
10.1	Amendment to the Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc..
12.1	Computation of ratio of earnings to fixed charges.
31.1	Certification of Chairman, President and Chief Executive Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Executive Vice President and Chief Financial Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chairman, President and Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Executive Vice President and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized as of October 23, 2007.

CENTENE CORPORATION

By:	/s/ MICHAEL F. NEIDORFF Chairman, President and Chief Executive Officer *(principal executive officer)*
By:	/s/ ERIC R. SLUSSER Executive Vice President and Chief Financial Officer *(principal financial officer)*
By:	/s/ J. PER BRODIN Senior Vice President, Chief Accounting Officer and Treasurer *(principal accounting officer)*