CENTENE CORP
Form S-4/A
May 25, 2007

AS FILED WITH THE SECURITIES AND EXCHANGE COMMISSION ON MAY 25, 2007

Registration Statement No. 333-142854

SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

Pre-Effective Amendment No. 1 to
FORM S-4

REGISTRATION STATEMENT
UNDER THE SECURITIES ACT OF 1933

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CENTENE CORPORATION
(Exact name of each registrant as specified in its respective charter)

Delaware	**6324**	**42-1406317**
(State or other jurisdiction of incorporation or organization)	(Primary standard industrial classification code number)	(I.R.S. employer identification number)

7711 Carondelet Avenue
St. Louis, Missouri 63105
(314) 725-4477
(Address, including zip code, and telephone number, including area code, of principal executive offices of each registrant)

_____

Keith H. Williamson
Centene Corporation
7711 Carondelet Avenue
St. Louis, Missouri 63105
(314) 725-4477
(Address, including zip code, and telephone number, including area code, of principal executive offices of each registrant)
Copies to:
J. Mark Klamer, Esq.
Bryan Cave LLP
211 N. Broadway
One Metropolitan Square, Suite 3600
St. Louis, Missouri 63102
Tel: (314) 259-2000
Fax: (314) 259-2020

Approximate date of commencement of proposed sale to the public: As soon as practicable after this Registration Statement becomes effective.

If the only securities being registered on this form are being offered in connection with the formation of a holding company and there is compliance with General Instruction G, check the following box: o

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

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

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

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

SUBJECT TO COMPLETION, DATED MAY 25, 2007

Centene Corporation

Offer to Exchange

$175,000,000 7¼% Senior Notes due 2014

for $175,000,000 7¼% Senior Notes due 2014

that have been registered under the Securities Act of 1933

We are offering to exchange an aggregate principal amount of up to $175,000,000 of our new 7¼% Senior Notes due 2014, which we refer to as the exchange notes, for a like amount of our outstanding 7¼% Senior Notes dues 2014, which we refer to as the outstanding notes, in a transaction registered under the Securities Act of 1933, as amended. The term "notes" refers to, collectively, the outstanding notes and the exchange notes.

Terms of the exchange offer:

- We will exchange all outstanding notes that are validly tendered and not withdrawn prior to the expiration of the exchange offer.
    - You may withdraw tenders of outstanding notes at any time prior to the expiration of the exchange offer.
- We believe that the exchange of outstanding notes for exchange notes will not be a taxable event for U.S. federal income tax purposes.
- The form and terms of the exchange notes are identical in all material respects to the form and terms of the outstanding notes, except that (i) the exchange notes are registered under the Securities Act, (ii) the transfer restrictions and registration rights applicable to the outstanding notes do not apply to the exchange notes, and (iii) the exchange notes will not contain provisions relating to liquidated damages relating to our registration obligations.

The exchange offer will expire at **, New York City time, on , 2007**, unless we extend the offer. We will announce any extension by press release or other permitted means no later than 9:00 a.m. on the business day after the expiration of the exchange offer. You may withdraw any outstanding notes tendered until the expiration of the exchange offer.

The exchange notes will not be listed on the New York Stock Exchange or any other securities exchange.

For a discussion of factors you should consider in determining whether to tender your outstanding notes, see the information under "Risk Factors" beginning on page 12 of this prospectus.

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

The date of this prospectus is , 2007.

We have not authorized anyone to give any information or to make any representations concerning this exchange offer except that which is in this prospectus, or which is referred to under "Where You Can Find More Information." If anyone gives or makes any other information or representation, you should not rely on it. This prospectus is not an offer to sell or a solicitation of an offer to buy securities in any circumstances in which the offer or solicitation is unlawful. You should not interpret the delivery of this prospectus, or any sale of securities, as an indication that there has been no change in our affairs since the date of this prospectus. You should also be aware that information in this prospectus may change after this date.

This prospectus incorporates by reference business and financial information about us that is not included in or delivered with this prospectus. This information is available without charge upon written or oral request directed to:

Centene Corporation
7711 Carondelet Avenue
St. Louis, Missouri 63105
(314) 725-4477
Attention: J. Per Brodin

If you would like to request copies of these documents, please do so by , 2007 in order to receive them before the expiration of the exchange offer.

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MARKET AND INDUSTRY DATA

Throughout this prospectus, we rely on and refer to information and statistics regarding the healthcare industry. We obtained this information and these statistics from various third-party sources, discussions with state regulators and our own internal estimates. We believe that these sources and estimates are reliable, but we have not independently verified them and cannot guarantee their accuracy or completeness.

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FORWARD-LOOKING STATEMENTS

This prospectus and the documents incorporated in this prospectus contain forward-looking statements. These forward-looking statements are made pursuant to the safe harbor provisions of the Private Securities Litigation Reform Act of 1995 and include estimates and assumptions related to economic, competitive and legislative developments. Forward-looking statements address our beliefs and expectations of the outcome of future events that are forward looking in nature, including, without limitation, the statements under "Prospectus Summary" and "Risk Factors." All statements other than statements of current or historical fact contained in this prospectus are forward-looking statements. The words "anticipate," "believe," "continue," "estimate," "expect," "intend," "plan," "may," "pro "will," and similar expressions, as they relate to us, are intended to identify these forward-looking statements. These statements are based on our current plans and not actual future activities, and our results of operations may be materially different from those set forth in the forward-looking statements due to a number of factors. In particular, these factors include, among other things:

- 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.

You should read and interpret any forward-looking statement together with the risk factors contained in this prospectus under the caption "Risk Factors."

All forward-looking statements included in this prospectus are based on information available to us on the date of this prospectus. Except as required by law, we undertake no obligation to update or revise any forward-looking statement, whether as a result of new information, future events or otherwise. All subsequent written and oral forward-looking statements attributable to us or persons acting on our behalf are expressly qualified in their entirety by the cautionary statements contained throughout this prospectus.

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PROSPECTUS SUMMARY

The following summary contains basic information about us and this offering. It is likely that this summary does not contain all of the information that is important to you. You should read the entire prospectus, including the risk factors and the financial statements and related notes included elsewhere herein, before making an investment decision. Unless otherwise indicated, the terms "Company," "us," "we" and "our" refers solely to Centene Corporation and its subsidiaries.

Our Company

We are a multi-line healthcare enterprise operating primarily in two segments: Medicaid Managed Care and Specialty Services. Our Medicaid Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program, or SCHIP, and Supplemental Security Income, or SSI. Medicaid currently accounts for 76% of our membership, while SCHIP and SSI account for 19% and 5%, respectively. Our Specialty Services segment provides specialty services, including behavioral health, disease management, long-term care programs, managed vision, nurse triage, pharmacy benefits management and treatment compliance, to state programs, healthcare organizations and other commercial organizations, as well as to our own subsidiaries on market-based terms. Our FirstGuard health plans exited the Kansas and Missouri markets effective January 1 and February 1, 2007, respectively. We were established in 1984, and our stock is publicly traded on the New York Stock Exchange under the ticker symbol "CNC." As of March 6, 2007, we had a market capitalization of approximately $1.04 billion. For the year ended December 31, 2006, our revenues, cash flow from operations and net loss were $2.3 billion, $195.0 million and $43.6 million, respectively. The net loss figure includes $94.5 million in pre-tax charges for intangible asset impairment and costs to exit Kansas and Missouri. For the quarter ended March 31, 2007, our revenues, cash flow from operations and net income were $670.8 million, $36.0 million and $38.2 million, respectively.

We receive a fixed monthly fee per member from states in which we operate in return for managing the benefits of our health plan members. Our revenues increase to the extent we can increase our membership or receive higher monthly premiums per member. Premium levels are established by the states with input from us. The premiums are required by Federal law to be actuarially sound. Our medical costs are determined by the healthcare services our members use. The keys to our profitability are to increase our membership, contract at appropriate rates with providers, and effectively control costs through medical management programs, such as disease management, preventative care and appropriate emergency room use.

Our Medicaid Managed Care membership totaled approximately 1.1 million as of March 31, 2007, an increase of 26% from March 31, 2006. We currently have six health plan subsidiaries offering healthcare services in Georgia, Indiana, New Jersey, Ohio, Texas and Wisconsin. Additionally, effective in April 2007, we acquired a Medicaid Medical Home Network in South Carolina and we expect to participate in the state rollout of Medicaid Managed Care in South Carolina. Our membership growth has come from expansion in both our existing markets and new markets. The following table sets forth information about each of our current health plans as of December 31, 2006:

State	Local Health Plan Name	First Year of Operations Under Centene	Counties Served at December 31, 2006	Market Share(1)	Membership at December 31, 2006
Georgia	Peach State Health Plan	2006	90	30.6%	308,800
Indiana	Managed Health Services	1995	92	33.4%	183,100

New Jersey	University Health Plans	2002	20	8.1%	58,900
Ohio	Buckeye Community Health Plan	2004	27	11.3%	109,200
Texas	Superior Health Plan	1999	217	21.0%	298,500
Wisconsin	Managed Health Services	1984	29	32.9%	164,800

(1) Represents Medicaid and SCHIP membership as of December 31, 2006 as a percentage of total eligible Medicaid and SCHIP members in each state. SSI programs are excluded.

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Our health plans facilitate access to healthcare services for members primarily through our contracts with providers. For each of our service areas, we establish a provider network consisting of primary and specialty care physicians, hospitals and ancillary providers. Our contracts with these physicians and providers are usually for one to two-year periods and renew automatically for successive one-year terms. As of December 31, 2006, our provider network included over 13,000 primary care physicians, such as family and general practitioners, pediatricians, internal medicine physicians and obstetrician/gynecologists, over 31,000 specialty care physicians, such as orthopedic surgeons, cardiologists and otolaryngologists, and over 600 hospitals. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services.

Our Specialty Services segment is a key component of our healthcare enterprise. These services diversify our products and revenue stream and help control our medical costs through improved disease management techniques. We provide member-focused services through locally-based staff by assisting in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. The following table sets forth information about each of our specialty services businesses:

Centene Commenced Operations	Description
2005	Respiratory-focused disease management
2006	Long-term care
2006	Cardiac-focused disease management
2003	Behavioral health plans
1998	Nurse phone line providing health education and triage advice
2006	Managed vision

2003	Prescription drug treatment compliance programs
2006	Pharmacy benefits management

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Our Industry

We provide our services to organizations and individuals primarily through Medicaid, SCHIP and SSI programs. The Congressional Budget Office, or CBO, estimates the total Medicaid market was approximately $330 billion in 2005, and the federal Centers for Medicare and Medicaid Services, or CMS, estimate the market will grow to over $450 billion by 2010. According to the most recent information provided by the Kaiser Commission on Medicaid and the Uninsured, Medicaid spending increased by 2.8% in fiscal 2006 and states appropriated an increase of 5.0% for Medicaid in fiscal 2007 budgets.

Established in 1965, Medicaid is the largest publicly funded program in the United States and provides health insurance to low-income families and individuals with disabilities. Authorized by Title XIX of the Social Security Act, Medicaid is an entitlement program funded jointly by the federal and state governments and administered by the states. The majority of funding is provided at the federal level. Each state establishes its own eligibility standards, benefit packages, payment rates and program administration within federal standards. As a result, there are 56 Medicaid programs—one for each U.S. state, each U.S. territory and the District of Columbia. An increasing number of states have mandated that their Medicaid recipients enroll in managed care plans as a means of delivering quality healthcare and controlling costs. Currently, 37 of the 56 programs, including each of the six states in which we operate health plans, have mandated managed care for some or all of their Medicaid recipients. Eligibility is based on a combination of household income and assets, often determined by an income level relative to the federal poverty level. Historically, children have represented the largest eligibility group.

Established in 1972 and authorized by Title XVI of the Social Security Act, SSI covers low-income persons with chronic physical disabilities or behavioral health impairments. SSI beneficiaries represent a growing portion of all Medicaid recipients. In addition, SSI recipients typically utilize more services because of their critical health issues.

The Balanced Budget Act of 1997 created SCHIP to help states expand coverage primarily to children whose families earn too much to qualify for Medicaid, yet not enough to afford private health insurance. Some states include the parents of these children in their SCHIP programs. SCHIP is the single largest expansion of health insurance coverage for children since the enactment of Medicaid. Costs related to the largest eligibility group, children, are primarily composed of pediatrics and family care. These costs tend to be more predictable than other healthcare issues which predominantly affect the adult population.

A portion of Medicaid beneficiaries are dual eligibles, low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. According to information provided by the Kaiser Commission on Medicaid and the Uninsured, dual eligibles account for 14% of Medicaid enrollees. These dual eligibles may receive assistance from Medicaid for Medicaid benefits, such as nursing home care, and/or assistance with Medicare premiums and cost sharing. Dual eligibles also use more services due to their tendency to have more chronic health issues.

Spending for Medicaid, SSI and SCHIP has increased steadily since 1988, with a compound annual growth rate, or CAGR, of 11% from 1988 through 2004, despite periods of recession.

Our Competitive Strengths

We believe a significant market opportunity exists for managed care organizations with operations and programs focused on the distinct socio-economic, cultural and healthcare needs of the Medicaid, SCHIP and SSI populations. We believe our approach and strategy enable us to be a growing participant in this market. Our multi-line managed care approach is based on the following key attributes:

*Strong Historic Operating Performance.*We have increased revenues as we have grown in existing markets, expanded into new markets and broadened our product menu. We entered the Wisconsin market in 1984, the Indiana market in 1995, the Texas market in 1999, the New Jersey market in 2002, the Ohio market in 2004 and the Georgia market in 2006. We have also increased membership by acquiring Medicaid businesses, contracts and other related assets from competitors in existing markets, most recently in Ohio in 2005 and 2006. We have increased our membership from 409,600 in 2002 to 1,103,300 as of March 31, 2007. For the year ended December 31, 2006, we had revenue of $2.3 billion, representing a 49% CAGR since the year ended December 31, 2002. We generated cash flow from operations of $195.0 million and a net loss of $43.6 million for the year ended December 31, 2006. The figures above include Kansas and Missouri, which we exited in January and February 2007, respectively, and which accounted for 138,900 members at December 31, 2006 and $317.0 million in revenue for the year ended December 31, 2006. For the quarter ended March 31, 2007, our revenues, cash flow from operations and net income were $670.8 million, $36.0 million and $38.2 million, respectively.

Medicaid Expertise. Over the last 20 years, we have strived to develop a specialized Medicaid expertise that has helped us establish and maintain relationships with members, providers and state governments. We have implemented programs developed to achieve savings for state governments and improve medical outcomes for members by reducing inappropriate emergency room use, inpatient days and high cost interventions, as well as by managing care of chronic illnesses. Our experience in working with state regulators helps us implement and deliver programs and services efficiently and affords us opportunities to provide input regarding Medicaid industry practices and policies in the states in which we operate. We work with state agencies on redefining benefits, eligibility requirements and provider fee schedules in order to maximize the number of uninsured individuals covered through Medicaid, SCHIP and SSI and expand the types of benefits offered. Our approach is to accomplish this while maintaining adequate levels of provider compensation and protecting our profitability.

Diversified Business Lines. We continue to broaden our service offerings to address areas that we believe have been traditionally underserved by Medicaid managed care organizations. In addition to our Medicaid and Medicaid-related managed care services, our service offerings include behavioral health plans, disease management, long-term care programs, managed vision, nurse triage, pharmacy benefits management and treatment compliance. Through the utilization of a multi-business line approach, we are able to diversify our revenue and help control our medical costs.

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Localized Approach with Centralized Support Infrastructure. We take a localized approach to managing our subsidiaries, including provider and member services. This approach enables us to facilitate access by our members to high quality, culturally sensitive healthcare services. Our systems and procedures have been designed to address community-specific challenges through outreach, education, transportation and other member support activities. For example, our community outreach programs work with our members and their communities to promote health and self-improvement through employment and education on how best to access care. We complement this localized approach with a centralized infrastructure of support functions such as finance, information systems and claims processing, which allows us to minimize general and administrative expenses and integrate and realize synergies from acquisitions. We believe this combined approach allows us to efficiently integrate new business opportunities in both Medicaid and specialty services while maintaining local accountability and improved access.

Specialized and Scalable Systems and Technology. Through our specialized information systems, we work to strengthen relationships with providers and states which help us grow our membership base. Our specialized information systems allow us to support our core processing functions under a set of integrated databases which are designed to be both replicable and scalable. Physicians can use claims, utilization and membership data to manage their practices more efficiently, and they also benefit from our timely payments. State agencies can use data from our information systems to demonstrate that their Medicaid populations receive quality healthcare in an efficient manner. These systems also help identify needs for new healthcare and specialty programs. We have the ability to leverage our platform for one state configuration into new states or for health plan acquisitions. Our ability to access data and translate it into meaningful information is essential to operating across a multi-state service area in a cost-effective manner.

*Experienced Management Team.*We have a management team who possess significant industry experience. Michael Neidorff, our Chairman and CEO, has been with us since 1996 and has over 20 years of experience in all aspects of managed care. Per Brodin, our Senior Vice President and Chief Financial Officer, has extensive experience as a financial and accounting officer both at Centene and other organizations. The other members of our senior management team are well-seasoned professionals with a broad range of capabilities including industry experience and functional expertise. This team has successfully managed the growth of our health plans and specialty businesses, while maintaining operational discipline.

Our Business Strategy

Our objective is to become the leading multi-line healthcare enterprise focusing on Medicaid and Medicaid-related services. We intend to achieve this objective by implementing the following key components of our strategy:

Increase Penetration of Existing State Markets. We seek to continue to increase our Medicaid membership in states in which we currently operate through alliances with key providers, outreach efforts, development and implementation of community-specific products and acquisitions. In 2006, we were awarded two regions in connection with Ohio's statewide restructuring of its Medicaid managed care program, expanding the number of counties we serve from three to 27. We also were awarded a Medicaid Aged, Blind or Disabled, or ABD, contract in four regions in Ohio. In Texas, we expanded our operations to the Corpus Christi market in 2006 and began managing care for SSI recipients in February 2007. We may also increase membership by acquiring Medicaid businesses, contracts and other related assets from our competitors in our existing markets or by enlisting additional providers. For example, in 2005 and 2006, we acquired certain Medicaid-related assets in Ohio.

Diversify Business Lines. We seek to broaden our business lines into areas that complement our existing business to enable us to grow and diversify our revenue. We are constantly evaluating new opportunities for expansion both domestically and abroad. For instance, in October 2006, we commenced operations under our managed care program

contracts to provide long-term care services in Arizona, and in January 2006, we completed the acquisition of US Script, a pharmacy benefits manager. We are also considering other premium based or fee-for-service lines of business that would provide additional diversity. We employ a disciplined acquisition strategy that is based on defined criteria including internal rate of return, accretion to earnings per share, market leadership and compatibility with our information systems. We engage our executives in the relevant operating units or functional areas to ensure consistency between the diligence and integration processes.

Address Emerging State Needs. We work to assist the states in which we operate in addressing the operating challenges they face. We seek to assist the states in balancing premium rates, benefit levels, member eligibility, policies and practices and provider compensation. For example, in 2005, we began performing under our contract with the State of Arizona to facilitate the delivery of mental health and substance abuse services to behavioral health recipients in Arizona. By helping states structure an appropriate level and range of Medicaid, SCHIP and specialty services, we seek to ensure that we are able to continue to provide those services on terms that achieve targeted gross margins, provide an acceptable return and grow our business.

Develop and Acquire Additional State Markets where Enrollment is Mandated. We continue to leverage our experience to identify and develop new markets by seeking both to acquire existing businesses and to build our own operations. We expect to focus expansion on states where Medicaid recipients are mandated to enroll in managed care organizations because we believe member enrollment levels are more predictable in these states. For example, effective June 1, 2006 we began managing care for Medicaid and SCHIP members in Georgia.

Leverage Established Infrastructure to Enhance Operating Efficiencies. We intend to continue to invest in infrastructure to further drive efficiencies in operations and to add functionality to improve the service provided to members and other organizations at a low cost. Our centralized functions enable us to add members and markets quickly and economically. For example, during 2005, we opened an additional claims processing facility to accommodate our planned growth initiatives for this centralized function.

Maintain Operational Discipline. We monitor our cost trends, operating performance, regulatory relationships and the Medicaid political environment in our existing markets. We seek to operate in markets that allow us to meet our internal metrics including membership growth, plan size, market leadership and operating efficiency. We may divest contracts or health plans in markets where the state’s Medicaid environment, over a long-term basis, does not allow us to meet our targeted performance levels. We use multiple techniques to monitor and reduce our medical costs, including on-site hospital review by staff nurses and involvement of medical management and finance personnel in significant cases. Our health economics unit and health plan controllers evaluate the financial impact of proposed changes in provider relationships. We also conduct monthly reviews of member demographics for each health plan.

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Additional Information

We are incorporated in Delaware and headquartered in St. Louis, Missouri. Our executive offices are located at 7711 Carondelet Avenue, St. Louis, Missouri 63105, and our telephone number is (314) 725-4477. Our website address is www.centene.com. Information contained on our website does not constitute a part of this prospectus.

THE EXCHANGE OFFER

On March 22, 2007, we issued $175,000,000 aggregate principal amount of 7¼% Senior Notes due 2014, the outstanding notes to which the exchange offer applies, to a group of initial purchasers in reliance on exemptions from, or in transactions not subject to, the registration requirements of the Securities Act and applicable securities laws. In connection with the sale of the outstanding notes to the initial purchasers, we entered into a registration rights agreement pursuant to which we agreed, among other things, to deliver this prospectus to you, to commence this exchange offer and to use our commercially reasonable efforts to complete the exchange offer within 180 days of the issuance of the outstanding notes. The summary below describes the principal terms and conditions of the exchange offer. Some of the terms and conditions described below are subject to important limitations and exceptions. See "The Exchange Offer" for a more detailed description of the terms and conditions of the exchange offer and "Description of the Exchange Notes" for a more detailed description of the terms of the exchange notes.

The Exchange Offer	We are offering to exchange up to $175,000,000 aggregate principal amount of our new 7¼% Senior Notes due 2014, which have been registered under the Securities Act, in exchange for your outstanding notes. The form and terms of these exchange notes are identical in all material respects to the outstanding notes. The exchange notes, however, will not contain transfer restrictions and registration rights applicable to the outstanding notes. To exchange your outstanding notes, you must properly tender them, and we must accept them. We will accept and exchange all outstanding notes that you validly tender and do not validly withdraw. We will issue registered exchange notes promptly after the expiration of the exchange offer.
Resale of Exchange Notes	Based on interpretations by the staff of the SEC as detailed in a series of no-action letters issued to third parties, we believe that, as long as you are not a broker-dealer, the exchange notes offered in the exchange offer may be offered for resale, resold or otherwise transferred by you without compliance with the registration and prospectus delivery requirements of the Securities Act as long as: · you are acquiring the exchange notes in the ordinary course of your business; · you are not participating, do not intend to participate in and have no arrangement or understanding with any person

to participate in a "distribution" of the exchange notes; and

· you are not an "affiliate" of ours within the meaning of Rule 405 of the Securities Act.

If any of these conditions is not satisfied and you transfer any exchange notes issued to you in the exchange offer without delivering a proper prospectus or without qualifying for a registration exemption, you may incur liability under the Securities Act. Moreover, our belief that transfers of exchange notes would be permitted without registration or prospectus delivery under the conditions described above is based on SEC interpretations given to other, unrelated issuers in similar exchange offers. We cannot assure you that the SEC would make a similar interpretation with respect to our exchange offer. We will not be responsible for or indemnify you against any liability you may incur under the Securities Act.

Any broker-dealer that acquires exchange notes for its own account in exchange for outstanding notes must represent that the outstanding notes to be exchanged for the exchange notes were acquired by it as a result of market-making activities or other trading activities and acknowledge that it will deliver a prospectus meeting the requirements of the Securities Act in connection with any offer to resell, resale or other retransfer of the exchange notes. However, by so acknowledging and by delivering a prospectus, such participating broker-dealer will not be deemed to admit that it is an "underwriter" within the meaning of the Securities Act. During the period ending 180 days after the consummation of the exchange offer, subject to extension in limited circumstances, a participating broker-dealer may use this prospectus for an offer to sell, a resale or other retransfer of exchange notes received in exchange for outstanding notes which it acquired through market-making activities or other trading activities.

Expiration Date

The exchange offer will expire at , New York City time, on , 2007, unless we extend the expiration date.

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Accrued Interest on the Exchange Notes and the Outstanding Notes	The exchange notes will bear interest from the most recent date to which interest has been paid on the outstanding notes. If your outstanding notes are accepted for exchange, then you will receive interest on the exchange notes and not on the outstanding notes. Any outstanding notes not tendered will remain outstanding and continue to accrue interest according to their terms.
Conditions	The exchange offer is subject to customary conditions. We may assert or waive these conditions in our sole discretion. If we materially change the terms of the exchange offer, we will resolicit tenders of the outstanding notes. See “The Exchange Offer—Conditions to the Exchange Offer” for more information regarding conditions to the exchange offer.
Procedures for Tendering Outstanding Notes	Each holder of outstanding notes that wishes to tender their outstanding notes must either: · complete, sign and date the accompanying letter of transmittal or a facsimile copy of the letter of transmittal, have the signatures on the letter of transmittal guaranteed, if required, and deliver the letter of transmittal, together with any other required documents (including the outstanding notes), to the exchange agent; or · if outstanding notes are tendered pursuant to book-entry procedures, the tendering holder must deliver a completed and duly executed letter of transmittal or arrange with Depository Trust Company, or DTC, to cause an agent’s message to be transmitted with the required information (including a book-entry confirmation) to the exchange agent; or · comply with the procedures set forth below under “—Guaranteed Delivery Procedures.” Holders of outstanding notes that tender outstanding notes in the exchange offer must represent that the following are true: · the holder is acquiring the exchange notes in the ordinary course of its business; · the holder is not participating in, does not intend to participate in, and has no arrangement or understanding with any person to participate in a “distribution” of the exchange notes; and

· the holder is not an "affiliate" of us within the meaning of Rule 405 of the Securities Act.

Do not send letters of transmittal, certificates representing outstanding notes or other documents to us or DTC. Send these documents only to the exchange agent at the appropriate address given in this prospectus and in the letter of transmittal. We could reject your tender of outstanding notes if you tender them in a manner that does not comply with the instructions provided in this prospectus and the accompanying letter of transmittal. See "Risk Factors—There are significant consequences if you fail to exchange your outstanding notes" for further information.

Special Procedures for Tenders by Beneficial Owners of Outstanding Notes

If:

· you beneficially own outstanding notes;

· those notes are registered in the name of a broker, dealer, commercial bank, trust company or other nominee; and

· you wish to tender your outstanding notes in the exchange offer,

please contact the registered holder as soon as possible and instruct it to tender on your behalf and comply with the instructions set forth in this prospectus and the letter of transmittal.

Guaranteed Delivery Procedures

If you hold outstanding notes in certificated form or if you own outstanding notes in the form of a book-entry interest in a global note deposited with the trustee, as custodian for DTC, and you wish to tender those outstanding notes but:

· your outstanding notes are not immediately available;

· time will not permit you to deliver the required documents to the exchange agent by the expiration date; or

· you cannot complete the procedure for book-entry transfer on time,

you may tender your outstanding notes pursuant to the procedures described in "The Exchange Offer—Procedures for Tendering Outstanding notes—Guaranteed Delivery."

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Withdrawal Rights	You may withdraw your tender of outstanding notes under the exchange offer at any time before the exchange offer expires. Any withdrawal must be in accordance with the procedures described in “The Exchange Offer—Withdrawal Rights.”
Effect on Holders of Outstanding Notes	As a result of making this exchange offer, and upon acceptance for exchange of all validly tendered outstanding notes, we will have fulfilled our obligations under the registration rights agreement. Accordingly, there will be no liquidated or other damages payable under the registration rights agreement if outstanding notes were eligible for exchange, but not exchanged, in the exchange offer. If you do not tender your outstanding notes or we reject your tender, your outstanding notes will remain outstanding and will be entitled to the benefits of the indenture governing the notes. Under such circumstances, you would not be entitled to any further registration rights under the registration rights agreement, except under limited circumstances. Existing transfer restrictions would continue to apply to the outstanding notes. Any trading market for the outstanding notes could be adversely affected if some but not all of the outstanding notes are tendered and accepted in the exchange offer.
Material U.S. Federal Income and Estate Tax Consequences	Your exchange of outstanding notes for exchange notes should not be treated as a taxable event for U.S. federal income tax purposes. See “Material U.S. Federal Income and Estate Tax Consequences.”
Use of Proceeds	We will not receive any proceeds from the exchange offer or the issuance of the exchange notes. $150.0 million of the net proceeds from the issuance of the outstanding notes were used to refinance our outstanding indebtedness under our revolving credit agreement and the remaining proceeds are available for general corporate purposes.

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SUMMARY OF TERMS OF EXCHANGE NOTES

The form and terms of the exchange notes will be identical in all material respects to the form and terms of the outstanding notes, except that the exchange notes:

• will have been registered under the Securities Act;

• will not bear restrictive legends restricting their transfer under the Securities Act;

• will not be entitled to the registration rights that apply to the outstanding notes; and

• will not contain provisions relating to an increase in the interest rate borne by the outstanding notes under circumstances related to the timing of the exchange offer.

The exchange notes represent the same debt as the outstanding notes and are governed by the same indenture, which is governed by New York law. A brief description of the material terms of the exchange notes follows:

Issuer	Centene Corporation
Notes Offered	$175,000,000 aggregate principal amount of 7 ¼ % Senior Notes due 2014.
Maturity Date	April 1, 2014.
Interest Payment Dates	April 1 and October 1, beginning October 1, 2007.
Ranking	The notes will be unsecured and rank equally with our senior debt and senior to our subordinated indebtedness. The notes will effectively rank junior to our subsidiaries' liabilities. The notes will also be subordinated to our secured indebtedness to the extent of the assets securing such indebtedness. As of December 31, 2006, after giving pro forma effect to this offering and our use of the net proceeds, · we would have had outstanding $175.0 million of senior indebtedness; and · our subsidiaries would have had outstanding $415.5 million of indebtedness and other liabilities, including trade payables and medical liabilities (excluding intercompany liabilities).
Option Redemption	Prior to April 1, 2011, we may from time to time redeem all or a portion of the notes by paying a special "make-whole" premium specified in this prospectus under "Description of the Exchange Notes — Optional Redemption." We may redeem some or all of the notes, at any time on or after April 1,

	2011 at the redemption prices described in this prospectus. See "Description of the Exchange Notes — Optional Redemption."
Equity Offering Optional Redemption	Before April 1, 2010, we may redeem up to 35% of the original aggregate principal amount of the notes with the net proceeds from certain equity offerings, at 107.250% of the principal amount of the notes, plus accrued and unpaid interest and additional interest, if any, to the redemption date, if at least 65% of the aggregate principal amount of the notes originally issued remains outstanding after such redemption.
Change of Control	When certain specified change of control events occur, each holder of notes may require us to repurchase all or a portion of its notes at a purchase price of 101% of the principal amount of such notes, plus accrued and unpaid interest and additional interest, if any, to the date of purchase. See "Description of the Exchange Notes — Repurchase at the Option of Holders — Change of Control."
Mandatory Offer to Repurchase Following Certain Asset Sales	If we sell certain assets and do not reinvest the net proceeds or repay senior debt in compliance with the indenture, we must offer to repurchase the notes at 100% of their principal amount, plus accrued and unpaid interest, with such proceeds. See "Description of the Exchange Notes — Repurchase at the Option of Holders — Asset Sales."

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Certain Covenants	The indenture governing the notes will contain covenants that, among other things, will limit our ability and the ability of our restricted subsidiaries to: · incur additional indebtedness and issue preferred stock, · pay dividends or make other distributions, · make other restricted payments and investments, · sell assets, including capital stock of restricted subsidiaries, · create certain liens, · enter into sale and leaseback transactions, · incur restrictions on the ability of restricted subsidiaries to pay dividends or make other payments, · in the case of our subsidiaries, guarantee indebtedness, · engage in transactions with affiliates, · create unrestricted subsidiaries, and · merge or consolidate with other entities. These covenants are subject to important exceptions and qualifications, that are described under the heading "Description of the Exchange Notes — Certain Covenants" in this prospectus. In addition, following the first day the notes have an investment grade rating from both Standard & Poor's Ratings Group, Inc. and Moody's Investors Service, Inc., subject to certain conditions, we and our restricted subsidiaries will not be subject to certain of these covenants. See "Description of Exchange Notes — Certain Covenants — Covenant Termination."
Absence of an Established Public Market for the Exchange Notes	The outstanding notes are presently eligible for trading through the PORTAL® Market of the Nasdaq Stock Market, Inc., but the exchange notes will be new securities for which there is currently no market. We do not intend to apply for a listing of the exchange notes

	on any securities exchange. Accordingly, we cannot assure you that a liquid market for the exchange notes will develop or be maintained.
Risk Factors	See “Risk Factors” and the other information in this prospectus for a discussion of factors you should carefully consider before deciding to participate in the exchange offer.

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SUMMARY FINANCIAL DATA

The following summary consolidated financial data should be read in connection with our Annual Report on Form 10-K for the year ended December 31, 2006 and our Quarterly Report on Form 10-Q for the quarter ended March 31, 2007, including the related notes to financial statements and "Management's Discussion and Analysis of Financial Condition and Results of Operations" contained therein, which are incorporated by reference elsewhere in this prospectus.

The data for the years ended December 31, 2004, 2005 and 2006 and as of December 31, 2004, 2005 and 2006 are derived from our audited consolidated financial statements, which are incorporated by reference elsewhere in this prospectus. The selected consolidated financial data as of and for the three months ended March 31, 2006 and March 31, 2007 are derived from our unaudited financial statements, which are incorporated by reference elsewhere in this prospectus. Historical results are not necessarily indicative of the results to be expected in the future.

	Year Ended December 31,			Three Months Ended March 31,	
	2004	2005	2006	2006	2007
	(dollars in thousands, except member data)			(unaudited)	
Statement of Operations Data:					
Revenues:					
Premium (1)	$ 991,673	$ 1,491,899	$ 2,199,439	$ 435,562	$ 649,243
Service	9,267	13,965	79,581	19,516	21,592
Total revenues	1,000,940	1,505,864	2,279,020	455,078	670,835
Expenses:					
Medical costs	800,476	1,226,909	1,819,811	361,672	535,406
Cost of services	8,065	5,851	60,735	15,588	15,630
General and administrative expenses (1)	127,863	193,913	346,284	65,222	106,866
Gain on sale of FirstGuard Missouri	—	—	—	—	(4,218)
Impairment loss	—	—	81,098	—	—
Total operating expenses	936,404	1,426,673	2,307,928	442,482	653,684
Earnings (loss) from operations	64,536	79,191	(28,908)	12,596	17,151
Other income (expense):					
Investment and other income	6,431	10,655	17,892	3,540	4,501
Interest expense	(680)	(3,990)	(10,636)	(1,998)	(3,132)
Earnings (loss) before income taxes	70,287	85,856	(21,652)	14,138	18,520
Income tax (benefit) expense	25,975	30,224	21,977	5,372	(19,691)
Net earnings (loss)	$ 44,312	$ 55,632	$ (43,629)	$ 8,766	$ 38,211
Balance Sheet Data:					
Cash and cash equivalents (2)	$ 84,105	$ 147,358	$ 271,047	$ 118,512	$ 311,905
Investments and restricted deposits (2)	233,257	202,916	237,603	221,249	250,883
Total assets	527,934	668,030	894,980	737,807	971,377
Medical claim liabilities	165,980	170,514	280,441	172,792	275,965
Long-term debt.	46,973	92,448	174,646	130,940	200,404

Stockholders' equity	271,312	352,048	326,423	364,249	369,464
Other Operating Data:					
Membership:					
Medicaid	484,700	573,100	887,300	574,300	839,600
SCHIP	142,200	134,600	216,200	132,000	211,200
SSI	10,400	14,900	19,800	15,800	52,500
Subtotal	637,300	722,600	1,123,300	722,100	1,103,300
Kansas and Missouri Medicaid/SCHIP members	135,400	149,300	138,900	152,700	—
Total	772,700	871,900	1,262,200	874,800	1,103,300
Revenue per Member (3)	$ 142.97	$ 146.14	$ 165.83	$ 157.17	$ 185.90
Health Benefits Ratio (4):					
Medicaid and SCHIP	80.4%	81.8%	82.6%	82.8%	82.3%
SSI	93.8%	97.5%	87.6%	87.6%	86.3%
Specialty Services	—	85.0%	82.5%	84.1%	79.3%
G&A Expense Ratio:					
Medicaid Managed Care	10.7%	10.5%	12.6%	11.9%	13.0%
Specialty Services	52.3%	35.4%	16.9%	22.3%	15.8%
Days in Claims Payable (5)	66.5	45.4	46.4	43.0	46.4

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	Year Ended December 31,			Three Months Ended March 31,	
	2004	2005	2006	2006	2007
	(dollars in thousands)				
				(unaudited)	
Other Financial Data:					
Net cash provided by operating activities	$ 99,405	$ 74,048	$ 195,032	$ 9,343	$ 35,980
Total debt to total capitalization					35.3%

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(1) Premium revenues and general and administrative expenses reflect the enactments of premium taxes in certain states. Premium taxes were $5,503, $9,802 and $42,453 for the years ended December 31, 2004, 2005 and 2006, respectively. Premium taxes were $4,305 and $18,216, respectively for the quarters ended March 31, 2006 and 2007. Premium revenues for the FirstGuard health plans, which we acquired on December 1, 2004 and exited in 2007, were $20,247, $273,662 and $317,027 for the years ended December 31, 2004, 2005 and 2006, respectively. Premium revenues for the FirstGuard health plans were $76,288 and $6,601, respectively for the quarters ended March 31, 2006 and 2007.

(2) Unregulated cash, cash equivalents and investments for the years ended December 31, 2004, 2005 and 2006 were $45,988, $27,680 and $28,852, respectively. Unregulated cash, cash equivalents and investments for the quarters ended March 31, 2006 and 2007 were $25,813 and $71,843, respectively.

(3) Revenue per member information is presented for the Medicaid Managed Care Segment.

(4) The health benefits ratio represents medical costs as a percentage of premium revenues. 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.

(5) Days in claims payable is a calculation of medical claims liabilities at the end of the period divided by average expense per calendar day for the applicable quarter of each period. Days in claims payable decreased in 2005 due to the settlement of a lawsuit with Aurora Health Care, Inc., information systems improvements to reduce our claims processing cycle time and the effect of our behavioral health contract in Arizona. Acquisitions in the last quarter of 2004 contributed to an increase in our 2004 days in claims payable.

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RISK FACTORS

You should carefully consider the risk factors set forth below, as well as the other information contained in this prospectus, before participating in this exchange offer. The risks described below are not the only risks facing us. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially and adversely affect our business operations. Any of the following risks could materially adversely affect our business, financial condition or results of operations.

Risks Relating to the Exchange Offer

***There are significant consequences if you fail t*o exchange your outstanding notes.**

We did not register the outstanding notes under the Securities Act or any state securities laws, nor do we intend to do so after the exchange offer. As a result, the outstanding notes may only be transferred in limited circumstances under the securities laws. If you do not exchange your outstanding notes in the exchange offer, you will lose your right to have the outstanding notes registered under the Securities Act, subject to certain limitations. If you continue to hold outstanding notes after the exchange offer, you may be unable to sell the outstanding notes. Outstanding notes that are not tendered or are tendered but not accepted will, following the exchange offer, continue to be subject to existing restrictions.

***You cannot be sure that an active trading market for t*he exchange notes will develop.**

While the outstanding notes are presently eligible for trading in the PORTAL® Market, there is no existing market for the exchange notes. We do not intend to apply for a listing of the exchange notes on any securities exchange. We do not know if an active public market for the exchange notes will develop or, if developed, will continue. If an active public market does not develop or is not maintained, the market price and liquidity of the exchange notes may be adversely affected. We cannot make any assurances regarding the liquidity of the market for the exchange notes, the ability of holders to sell their exchange notes or the price at which holders may sell their exchange notes. In addition, the liquidity and the market price of the exchange notes may be adversely affected by changes in the overall market for securities similar to the exchange notes, by changes in our financial performance or prospects and by changes in conditions in our industry.

***You must follow the appropriate procedures to tender your* outstanding notes or they will not be exchanged.**

The exchange notes will be issued in exchange for the outstanding notes only after timely receipt by the exchange agent of the outstanding notes or a book-entry confirmation related thereto, a properly completed and executed letter of transmittal or an agent's message and all other required documentation. If you want to tender your outstanding notes in exchange for exchange notes, you should allow sufficient time to ensure timely delivery. Neither we nor the exchange agent are under any duty to give you notification of defects or irregularities with respect to tenders of outstanding notes for exchange. Outstanding notes that are not tendered or are tendered but not accepted will, following the exchange offer, continue to be subject to the existing transfer restrictions. In addition, if you tender the outstanding notes in the exchange offer to participate in a distribution of the exchange notes, you will be required to comply with the registration and prospectus delivery requirements of the Securities Act in connection with any resale transaction. For additional information, please refer to the sections entitled "The Exchange Offer" and "Plan of Distribution" later in this prospectus.

Risks Related to Being a Regulated Entity

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

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

For example, in August 2006, the Centers for Medicare & Medicaid Services, or CMS, published an interim final rule regarding the estimation and recovery of improper payments made under Medicaid and SCHIP. This rule requires a CMS contractor to sample selected states each year to estimate improper payments in Medicaid and SCHIP and create national and state specific error rates. States must provide information to measure improper payments in Medicaid managed care, as well as in fee-for-service Medicaid. Each state will be selected for review once every three years for each program. States are required to repay CMS the federal share of any overpayments identified.

On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 to reduce the size of the federal deficit. The Act reduces federal spending by nearly $40 billion over 5 years, including a $5 billion reduction in Medicaid. The Act reduces spending by cutting Medicaid payments for prescription drugs and gives states new power to reduce or reconfigure benefits. This law may also lead to lower Medicaid reimbursements in some states. The Bush administration's budget proposal for fiscal year 2008 proposes cutting Medicaid funding by $1.9 billion in legislative changes and by $1.5 billion in administrative changes, which would lead to $25.7 billion in funding reductions over five years when compared to the fiscal year 2007 levels. Additionally, the Bush administration's 2008 budget for SCHIP provides for yearly allotments at the fiscal year 2007 levels, plus an additional $5 billion over the five-year period, which some believe will result in a funding shortfall. States also periodically consider reducing or reallocating the amount of money they spend for Medicaid, SCHIP and SSI. In recent years, the majority of states have implemented measures to restrict Medicaid, SCHIP and SSI costs and eligibility.

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

If SCHIP is not reauthorized, our business could suffer.

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

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

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

We provide managed care programs and selected services to individuals receiving benefits under federal assistance programs, including Medicaid, SCHIP and SSI. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. Our contracts with various states are generally intended to run for one or two years and may be extended for one or two additional years if the state or its agent elects to do so. Our current contracts are set to expire between June 30, 2007 and September 30, 2011. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. For example, on August 25, 2006, we received notification from the Kansas Health Policy Authority that FirstGuard Health Plan Kansas, Inc.'s contract with the state would not be renewed or extended, and as a result, our contract ended on December 31, 2006. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds. Our contracts could also be terminated if we fail to perform in accordance with the standards set by state regulatory agencies. For example, the Indiana contract under which we operate can be terminated by the State without cause. If any of our contracts are terminated, not renewed, or renewed on less favorable terms, our business will suffer, and our operating results may be materially affected.

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

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

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

· increase or change our liability to members in the event of malpractice by our providers.

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

Regulations may decrease the profitability of our health plans.

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

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

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

· refunding of amounts we have been paid pursuant to our contracts;

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- imposition of fines, penalties and other sanctions on us;
- loss of our right to participate in various markets;
- increased difficulty in selling our products and services; and
- loss of one or more of our licenses.

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

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

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

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

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

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

The Sarbanes-Oxley Act requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on the effectiveness of our internal controls over our financial reporting as required by Section 404 of the Sarbanes-Oxley Act. Our testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting

that are deemed to be material weaknesses. Our compliance with Section 404 requires that we incur substantial accounting expense and expend significant management efforts. Moreover, if we are not able to comply with the requirements of Section 404, or if we or our independent registered public accounting firm identifies deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the NYSE, SEC or other regulatory authorities, which would require additional financial and management resources.

Changes in healthcare law and benefits may reduce our profitability.

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

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

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

Changes in federal funding mechanisms may reduce our profitability.

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

In April 2004, the Bush administration adopted a policy that seeks to reduce states' use of intergovernmental transfers for the states' share of Medicaid program funding. By restricting the use of intergovernmental transfers, this policy, if continued, may restrict some states' funding for Medicaid, which could adversely affect our growth, operations and financial performance.

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

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

Our operations are conducted through our wholly owned subsidiaries, which include health maintenance organizations, or HMOs, and managed care organizations, or MCOs. HMOs and MCOs are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Additionally, state regulatory agencies may require, at their discretion, individual HMOs to maintain statutory capital levels higher than the state regulations. If this were to occur to one of our subsidiaries, we may be required to make additional capital contributions to the affected subsidiary. Any additional capital contribution made to one of the affected subsidiaries could have a material adverse effect on our liquidity and our ability to grow.

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

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

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

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

Risks Related to Our Business

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

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

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

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

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

Our premium revenues consist of fixed monthly payments per member and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide healthcare services as established by the state governments. We use a large portion of our revenues to pay the costs of healthcare services delivered to our members. If premiums do not increase when expenses related to medical services rise, our earnings will be affected negatively. In addition, our actual medical service 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.

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

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

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

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

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

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

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

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

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

integration of:

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

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

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

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

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

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

Start-up costs associated with a new business can be substantial. For example, in order to obtain a certificate of authority in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to obtain a state contract and process claims.

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If we were unsuccessful in obtaining the necessary license, winning the bid to provide service or attracting members in numbers sufficient to cover our costs, any new business of ours would fail. We also could be obligated by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or recover start-up costs. The expenses associated with starting up a new business could have a significant impact on our results of operations if we are unable to achieve profitable operations in a timely fashion.

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

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

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

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

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

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

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

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

From time to time, providers assert or threaten to assert claims seeking to terminate noncancelable agreements due to alleged actions or inactions by us. Even if these allegations represent attempts to avoid or renegotiate contractual terms that have become economically disadvantageous to the providers, it is possible that in the future a provider may pursue such a claim successfully. In addition, we are aware that other managed care organizations have been subject to

class action suits by physicians with respect to claim payment procedures, and we may be subject to similar claims. Regardless of whether any claims brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively.

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

We may be unable to attract and retain key personnel.

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

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

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

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

Our providers and employees involved in medical care decisions may be subject to medical malpractice claims. In addition, some states, including Texas, have adopted legislation that permits managed care organizations to be held liable for negligent treatment decisions or benefits coverage determinations. Claims of this nature, if successful, could result in substantial damage awards against us and our providers that could exceed the limits of any applicable insurance coverage. Therefore, successful malpractice or tort claims asserted against us, our providers or our employees could adversely affect our financial condition and profitability.

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Even if any claims brought against us are unsuccessful or without merit, they would still be time consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Risks Related to the Notes

To service our indebtedness, we will require a significant amount of cash. Our ability to generate cash depends on many factors beyond our control.

Our ability to make payments on and to refinance our indebtedness, including the notes, and to fund planned capital expenditures will depend on our ability and the ability of our subsidiaries to generate cash in the future. This, to a certain extent, is subject to general economic, financial, competitive, legislative, regulatory and other factors that are beyond our control.

We cannot assure you that our business will generate sufficient cash flow from operations, or that future borrowings will be available to us under our revolving credit facility in an amount sufficient to enable us to pay our indebtedness, including these notes, or to fund our other liquidity needs. We may need to refinance all or a portion of our indebtedness, including the notes, on or before maturity. We cannot assure you that we will be able to refinance any of our indebtedness, including any current or future credit facility and the notes, on commercially reasonable terms or at all.

The restrictive covenants in our debt instruments may limit our operating flexibility. Our failure to comply with these covenants could result in defaults under our indenture and future debt instruments even though we may be able to meet our debt service obligations.

The instruments governing our indebtedness, including the indenture governing the notes and the revolving credit facility, impose significant operating and financial restrictions on us. These restrictions significantly limit, among other things, our ability to incur additional indebtedness, pay dividends, repay junior indebtedness, sell assets, make investments, engage in transactions with affiliates, create liens and engage in certain types of mergers or acquisitions. Our future debt instruments may have similar or more restrictive covenants. These restrictions could limit our ability to obtain future financings, make capital expenditures, withstand a future downturn in our business or the economy in general, or otherwise take advantage of business opportunities that may arise. If we fail to comply with these restrictions, the note holders or lenders under any debt instrument could declare a default under the terms of the relevant indebtedness even though we are able to meet debt service obligations and, because our indebtedness has cross-default and cross-acceleration provisions, could cause all of our debt to become immediately due and payable.

We cannot assure you that we would have sufficient funds available, or that we would have access to sufficient capital from other sources, to repay any accelerated debt. Even if we could obtain additional financing, we cannot assure you that the terms would be favorable to us. If we default on any future secured debt, the secured creditors could foreclose on their liens. As a result, any event of default could have a material adverse effect on our business and financial condition, and could prevent us from paying amounts due under the notes.

Despite current indebtedness levels, we may still be able to incur substantially more debt, including secured debt.

We and our subsidiaries may be able to incur substantial additional indebtedness in the future, including secured indebtedness. The terms of the indenture governing the notes do not fully prohibit us or our subsidiaries from doing so. Our revolving credit facility would permit borrowing up to $300 million after completion of this offering and the application of proceeds to repay amounts outstanding thereunder. If new debt is added to our current debt levels, the related risks we now face could intensify.

In addition, a substantial amount of debt we incur in the future could be secured. To the extent we were to secure debt we incur in the future under any credit facility or other issuance of debt, your ability to receive payments under the notes will be effectively subordinated to the secured debt, which will have a prior claim on any assets securing the debt, to the extent of the value of those assets.

Because we are a holding company and depend entirely on cash flow from our subsidiaries to meet our obligations, your right to receive payment on the notes will be effectively subordinated to our subsidiaries' obligations.

The notes will be obligations exclusively of Centene. Our cash flow and our ability to service our debt, including the notes, depends on the earnings of our subsidiaries and on the distribution of earnings, loans or other payments to us by our subsidiaries.

Our subsidiaries are separate and distinct legal entities with no obligations to pay any amounts due on the notes or to provide us with funds for our payment obligations, whether by dividend, distribution, loan or other payments. In addition, the ability of our subsidiaries to make any dividend, distribution, loan or other payment to us is subject to statutory restrictions, regulatory capital requirements and contractual restrictions, including under the revolving credit facility. Payments to us by our subsidiaries will also be contingent upon our subsidiaries' earnings and their business considerations.

Our right to receive any assets of our subsidiaries upon their bankruptcy, liquidation, dissolution, reorganization or similar proceeding, and therefore your right to participate in those assets, will be effectively subordinated to the claims of those subsidiaries' creditors, including trace creditors. In addition, even if Centene were a creditor of one or more of our subsidiaries, our rights as a creditor would be subordinated to any security interest in the assets of those subsidiaries and any debt of our subsidiaries senior to that held by us. As a result, the notes will be effectively subordinated to all liabilities, including trade payables, of our current or future subsidiaries. Because we depend on the cash flow of our subsidiaries to meet our own obligations, including with respect to the notes, these types of restrictions could impair our ability to make scheduled interest payments on the notes and to pay the principal at maturity. As of December 31, 2006, the notes would have been effectively subordinated, on a pro forma basis as adjusted for the offering and the use of proceeds therefrom, to $415.5 million of liabilities outstanding of our subsidiaries, including trade payables and medical claims liabilities (excluding intercompany liabilities).

In addition, our regulated subsidiaries have historically generated substantially all of our revenues. If one or more of our regulated subsidiaries becomes insolvent, the regulators may seize its assets to cover its obligations under healthcare policies, which could result in our remaining assets generating insufficient revenue to pay the notes in full or at all.

We may not have the ability to raise the funds necessary to finance the change of control offer required by the indenture.

Upon a change of control, we will be required to offer to repurchase all outstanding notes at 101% of the principal amount thereof plus accrued and unpaid interest and additional interest, if any, to the date of repurchase. However, it is possible that we will not have sufficient funds at the time of the change of control to make the required repurchase of notes or that restrictions in our revolving credit facility or any other future indebtedness will not allow such repurchases. In addition, certain important corporate events, such as leveraged recapitalizations that would increase the level of our indebtedness, would not constitute a "change of control" under the indenture. See "Description of the Exchange Notes —Repurchase at Option of Holders."

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USE OF PROCEEDS

We will not receive any proceeds from the exchange offer. Because the exchange notes have substantially identical terms as the outstanding notes, the issuance of the exchange notes will not result in any increase in our indebtedness. The exchange offer is intended to satisfy our obligations under the registration rights agreement. Gross proceeds from the offering of the outstanding notes were approximately $169.8 million, after deducting the discounts and estimated offering expenses. We used the proceeds from the sale of the outstanding notes to refinance approximately $150.0 million of our existing indebtedness under our revolving credit facility and any additional proceeds are available for general corporate purposes.

CAPITALIZATION

The following table sets forth our consolidated cash and cash equivalents, investments and restricted deposits, and capitalization as of March 31, 2007.

	March 31, 2007 (dollars in thousands)
Unregulated cash and investments	$ 71,843
Regulated cash, investments and restricted deposits	490,945
Total cash, investments and restricted deposits	$ 562,788
Revolving credit facility	$ —
7¼% Senior Notes due 2014	175,000
Debt secured by real estate	20,725
Capital leases	5,644
Total debt	201,369
Stockholders' equity	369,464
Total capitalization	$ 570,833

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SELECTED HISTORICAL FINANCIAL DATA

The following summary consolidated financial data should be read in connection with our Annual Report on Form 10-K for the year ended December 31, 2006 and our Quarterly Report on Form 10-Q for the quarter ended March 31, 2007, including the related notes to financial statements and "Management's Discussion and Analysis of Financial Condition and Results of Operations" contained therein, which are incorporated by reference elsewhere in this prospectus.

The data for and as of the end of each of the last five fiscal years are derived from our audited consolidated financial statements. Historical results are not necessarily indicative of the results to be expected in the future.

	Year Ended December 31,					Three Months Ended March 31,	
	2002	2003	2004	2005	2006	2006	2007
	(dollars in thousands, except per share data)						
						(unaudited)	
Statement of Earnings Data:							
Revenues:							
Premium (1)	$ 461,030	$ 759,763	$ 991,673	$ 1,491,899	$ 2,199,439	$ 435,562	$ 649,243
Service	457	9,967	9,267	13,965	79,581	19,516	21,592
Total Revenues	461,487	769,730	1,000,940	1,505,864	2,279,020	455,078	670,835
Expenses:							
Medical costs	379,468	626,192	800,476	1,226,909	1,819,811	361,672	535,406
Cost of services	341	8,323	8,065	5,851	60,735	15,588	15,630
General and administrative expenses (1)	50,072	88,288	127,863	193,913	346,284	65,222	106,866
Gain on sale of FirstGuard Missouri	—	—	—	—	—	—	(4,218)
Impairment loss	—	—	—	—	81,098	—	—
Total operating expenses	429,881	722,803	936,404	1,426,673	2,307,928	442,482	653,684
Earnings (loss) from operations	31,606	46,927	64,536	79,191	(28,908)	12,596	17,151
Other income (expense):							
Investment and other income	9,575	5,160	6,431	10,655	17,892	3,540	4,501
Interest expense	(45)	(194)	(680)	(3,990)	(10,636)	(1,998)	(3,132)
Earnings (loss) before income taxes	41,136	51,893	70,287	85,856	(21,652)	14,138	18,520
Income tax (benefit) expense	15,631	19,504	25,975	30,224	21,977	5,372	(19,691)

Minority interest	116	881	—	—	—	—	—
Net earnings (loss)	$ 25,621	$ 33,270	$ 44,312	$ 55,632	$ (43,629)	$ 8,766	$ 38,211
Net earnings (loss) per common share:							
Basic	$ 0.82	$ 0.93	$ 1.09	$ 1.31	$ (1.01)	$ 0.20	$ 0.88
Diluted	$ 0.73	$ 0.87	$ 1.02	$ 1.24	$ (1.01)	$ 0.20	$ 0.85
Weighted average number of common shares outstanding:							
Basic	31,432,080	35,704,426	40,820,909	42,312,522	43,160,860	42,987,892	43,433,319
Diluted	34,932,232	38,422,152	43,616,445	45,027,633	43,160,860	44,750,271	44,923,340
Ratio of earnings to fixed charges (2)	45.96	43.12	29.24	14.20	—	5.90	5.39

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	December 31,					March 31,	
	2002	2003	2004	2005	2006	2006	2007
	(dollars in thousands)						
						(unaudited)	
Balance Sheet Data							
Cash and cash equivalents (3)	$ 59,656	$ 64,346	$ 84,105	$ 147,358	$ 271,047	$ 118,512	$ 311,905
Investments and restricted deposits (3)	104,999	220,335	233,257	202,916	237,603	221,249	250,883
Total assets	210,327	362,692	527,934	668,030	894,980	737,807	971,377
Medical claims liabilities	91,181	106,569	165,980	170,514	280,441	172,792	275,965
Long-term debt	—	7,616	46,973	92,448	174,646	130,940	200,404
Total stockholders' equity	102,183	220,115	271,312	352,048	326,423	364,249	369,464

(1) Premium revenues and general and administrative expenses reflect the enactments of premium taxes in certain states. Premium taxes were $0, $1,425, $5,503, $9,802 and $42,453 for the years ended December 31, 2002, 2003, 2004, 2005 and 2006, respectively. Premium taxes were $4,305 and $18,216, respectively for the quarters ended March 31, 2006 and 2007. Premium revenues for the FirstGuard health plans, which we acquired on December 1, 2004 and exited in 2007, were $20,247, $273,662 and $317,027 for the years ended December 31, 2004, 2005 and 2006, respectively. Premium revenues for the FirstGuard health plans were $76,288 and $6,601, respectively for the quarters ended March 31, 2006 and 2007.

(2) For the purpose of calculating the ratios of earning to fixed charges, earnings consist of loss from continuing operations before income taxes and fixed charges. Fixed charges consist of interest expense and the portion of rental expense (approximately one-third) that management believes represents the interest component of rent expense. For the year ended December 31, 2006, earnings were insufficient to cover fixed charges by $21,652. The deficiency of earnings to fixed charges for this period includes the effect of $94,470 in pre-tax charges for intangible asset impairment and costs to exit Kansas and Missouri.

(3) Unregulated cash, cash equivalents and investments for the years ended December 31, 2002, 2003, 2004, 2005 and 2006 were $51,970, $126,675, $45,988, $27,680 and $28,852, respectively. Unregulated cash, cash equivalents and investments for the quarters ended March 31, 2006 and 2007 were $25,813 and $71,843, respectively.

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BUSINESS

Overview

We are a multi-line healthcare enterprise operating primarily in two segments: Medicaid Managed Care and Specialty Services. Our Medicaid Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program, or SCHIP, and Supplemental Security Income, or SSI. Medicaid currently accounts for 76% of our membership, while SCHIP and SSI account for 19% and 5%, respectively. Our Specialty Services segment provides specialty services, including behavioral health, disease management, long-term care programs, managed vision, nurse triage, pharmacy benefits management and treatment compliance, to state programs, healthcare organizations and other commercial organizations, as well as to our own subsidiaries on market-based terms. Our FirstGuard health plans exited the Kansas and Missouri markets effective January 1 and February 1, 2007, respectively. As of March 6, 2007 we had a market capitalization of approximately $1.04 billion. For the year ended December 31, 2006, our revenues, cash flow from operations, and net loss were $2.3 billion, $195.0 million and $43.6 million, respectively. The net loss figure includes $94.5 million in pre-tax charges for intangible asset impairment and costs to exit Kansas and Missouri. For the quarter ended March 31, 2007, our revenues, cash flow from operations and net income were $670.8 million, $36.0 million and $38.2 million, respectively.

Our Medicaid Managed Care membership totaled approximately 1.1 million as of March 31, 2007, an increase of 26% from March 31, 2006. We currently have six health plan subsidiaries offering healthcare services in Georgia, Indiana, New Jersey, Ohio, Texas and Wisconsin. Additionally, effective in April 2007, we acquired a Medicaid Medical Home Network in South Carolina and we expect to participate in the state rollout of Medicaid Managed Care in South Carolina. We provide member-focused services through locally based staff by assisting in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services.

We believe our local approach to managing our subsidiaries, including provider and member services, enables us to provide accessible, quality, culturally-sensitive healthcare coverage to our communities. Our disease management, educational and other initiatives are designed to help members best utilize the healthcare system to ensure they receive appropriate, medically necessary services and effective management of routine, severe and chronic health problems, resulting in better health outcomes. We combine our decentralized local approach for care with a centralized infrastructure of support functions such as finance, information systems and claims processing.

Our initial health plan commenced operations in Wisconsin in 1984. We were organized in Wisconsin in 1993 as a holding company for our initial health plan and reincorporated in Delaware in 2001. We are headquartered in St. Louis, Missouri and our stock is publicly traded on the New York Stock Exchange under the ticker symbol "CNC."

Industry

We provide our services to organizations and individuals primarily through Medicaid, SCHIP and SSI programs. The Congressional Budget Office, or CBO, estimated the total Medicaid market was approximately $330 billion in 2005, and the federal Centers for Medicare and Medicaid Services, or CMS, estimate the market will grow to over $450 billion by 2010. According to the most recent information provided by the Kaiser Commission on Medicaid and the Uninsured, Medicaid spending increased by 2.8% in fiscal 2006 and states appropriated an increase of 5.0% for Medicaid in fiscal 2007 budgets.

Established in 1965, Medicaid is the largest publicly funded program in the United States, and provides health insurance to low-income families and individuals with disabilities. Authorized by Title XIX of the Social Security Act, Medicaid is an entitlement program funded jointly by the federal and state governments and administered by the

states. The majority of funding is provided at the federal level. Each state establishes its own eligibility standards, benefit packages, payment rates and program administration within federal standards. As a result, there are 56 Medicaid programs— one for each U.S. state, each U.S. territory and the District of Columbia. An increasing number of states have mandated that their Medicaid recipients enroll in managed care plans as a means of delivering quality healthcare and controlling costs. Currently, 37 of the 56 programs, including each of the six states in which we operate health plans, have mandated managed care for some or all of their Medicaid recipients. Eligibility is based on a combination of household income and assets, often determined by an income level relative to the federal poverty level. Historically, children have represented the largest eligibility group.

Established in 1972, and authorized by Title XVI of the Social Security Act, SSI covers low-income persons with chronic physical disabilities or behavioral health impairments. SSI beneficiaries represent a growing portion of all Medicaid recipients. In addition, SSI recipients typically utilize more services because of their critical health issues.

The Balanced Budget Act of 1997 created SCHIP to help states expand coverage primarily to children whose families earned too much to qualify for Medicaid, yet not enough to afford private health insurance. Some states include the parents of these children in their SCHIP programs. SCHIP is the single largest expansion of health insurance coverage for children since the enactment of Medicaid. Costs related to the largest eligibility group, children, are primarily composed of pediatrics and family care. These costs tend to be more predictable than other healthcare issues which predominantly affect the adult population.

A portion of Medicaid beneficiaries are dual eligibles, low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. According to information provided by the Kaiser Commission on Medicaid and the Uninsured, dual eligibles account for 14% of Medicaid enrollees. These dual eligibles may receive assistance from Medicaid for Medicaid benefits, such as nursing home care and/or assistance with Medicare premiums and cost sharing. Dual eligibles also use more services due to their tendency to have more chronic health issues. We serve dual eligibles through our SSI and long-term care programs.

While Medicaid programs have directed funds to many individuals who cannot afford or otherwise maintain health insurance coverage, they did not initially address the inefficient and costly manner in which the Medicaid population tends to access healthcare. Medicaid recipients in non-managed care programs typically have not sought preventive care or routine treatment for chronic conditions, such as asthma and diabetes. Rather, they have sought healthcare in hospital emergency rooms, which tends to be more expensive. As a result, many states have found that the costs of providing Medicaid benefits have increased while the medical outcomes for the recipients remained unsatisfactory.

Since the early 1980s, increasing healthcare costs, combined with significant growth in the number of Medicaid recipients, have led many states to establish Medicaid managed care initiatives. Continued pressure on states' Medicaid budgets should cause public policy to recognize the value of managed care as a means of delivering quality healthcare and effectively controlling costs. A growing number of states, including each of the six states in which we operate health plans, have mandated that their Medicaid recipients enroll in managed care plans. Other states are considering moving to a mandated managed care approach. As a result, a significant market opportunity exists for managed care organizations with operations and programs focused on the distinct socio-economic, cultural and healthcare needs of the Medicaid, SCHIP and SSI populations. We believe our approach and strategy enable us to be a growing participant in this market.

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Our Competitive Strengths

Our multi-line managed care approach is based on the following key attributes:

Strong Historic Operating Performance. We have increased revenues as we have grown in existing markets, expanded into new markets and broadened our product menu. We entered the Wisconsin market in 1984, the Indiana market in 1995, the Texas market in 1999, the New Jersey market in 2002, the Ohio market in 2004 and the Georgia market in 2006. We have also increased membership by acquiring Medicaid businesses, contracts and other related assets from competitors in existing markets, most recently in Ohio in 2005 and 2006. Our Medicaid Managed Care membership totaled approximately 1.1 million as of March 31, 2007, an increase of 26% from March 31, 2006. For the year ended December 31, 2006, we had revenue of $2.3 billion, representing a 49% CAGR since the year ended December 31, 2002. We generated cash flow from operations of $195.0 million and a net loss of $43.6 million for the year ended December 31, 2006. The figures above include Kansas and Missouri, which we exited in January and February 2007, respectively, and which accounted for 138,900 members at December 31, 2006 and $317.0 million in revenue for the year ended December 31, 2006. For the quarter ended March 31, 2007, our revenues, cash flow from operations and net income were $670.8 million, $36.0 million and $38.2 million, respectively.

Medicaid Expertise. Over the last 20 years, we have strived to develop a specialized Medicaid expertise that has helped us establish and maintain relationships with members, providers and state governments. We have implemented programs developed to achieve savings for state governments and improve medical outcomes for members by reducing inappropriate emergency room use, inpatient days and high cost interventions, as well as by managing care of chronic illnesses. Our experience in working with state regulators helps us implement and deliver programs and services efficiently and affords us opportunities to provide input regarding Medicaid industry practices and policies in the states in which we operate. We work with state agencies on redefining benefits, eligibility requirements and provider fee schedules in order to maximize the number of uninsured individuals covered through Medicaid, SCHIP and SSI and expand these types of benefits offered. Our approach is to accomplish this while maintaining adequate levels of provider compensation and protecting our profitability.

Diversified Business Lines. We continue to broaden our service offerings to address areas that we believe have been traditionally underserved by Medicaid managed care organizations. In addition to our Medicaid and Medicaid-related managed care services, our service offerings include behavioral health, disease management, long-term care programs, managed vision, nurse triage, pharmacy benefits management and treatment compliance. Through the utilization of a multi-business line approach, we are able to diversify our revenue and help control our medical costs.

Localized Approach with Centralized Support Infrastructure. We take a localized approach to managing our subsidiaries, including provider and member services. This approach enables us to facilitate access by our members to high quality, culturally sensitive healthcare services. Our systems and procedures have been designed to address these community-specific challenges through outreach, education, transportation and other member support activities. For example, our community outreach programs work with our members and their communities to promote health and self-improvement through employment and education on how best to access care. We complement this localized approach with a centralized infrastructure of support functions such as finance, information systems and claims processing, which allows us to minimize general and administrative expenses and to integrate and realize synergies from acquisitions. We believe this combined approach allows us to efficiently integrate new business opportunities in both Medicaid and specialty services while maintaining our local accountability and improved access.

Specialized and Scalable Systems and Technology. Through our specialized information systems, we work to strengthen relationships with providers and states which help us grow our membership base. Our specialized information systems allow us to support our core processing functions under a set of integrated databases which are designed to be both replicable and scalable. Physicians can use claims, utilization and membership data to manage

their practices more efficiently, and they also benefit from our timely payments. State agencies can use data from our information systems to demonstrate that their Medicaid populations receive quality healthcare in an efficient manner. These systems also help identify needs for new healthcare and specialty programs. We have the ability to leverage our platform for one state configuration into new states or for health plan acquisitions. Our ability to access data and translate it into meaningful information is essential to operating across a multi-state service area in a cost-effective manner.

Experienced Management Team. We have a management team who possess significant industry experience. Michael Neidorff, our Chairman and CEO, has been with us since 1996 and has over 20 years of experience in all aspects of managed care. Per Brodin, our Senior Vice President and Chief Financial Officer, has extensive experience as a financial and accounting officer both at Centene and other organizations. The other members of our senior management team are well-seasoned professionals with a broad range of capabilities including industry experience and functional expertise. This team has successfully managed the growth of our health plans and specialty businesses, while maintaining operational discipline.

Our Business Strategy

Our objective is to become the leading multi-line healthcare enterprise focusing on Medicaid and Medicaid-related services. We intend to achieve this objective by implementing the following key components of our strategy:

Increase Penetration of Existing State Markets. We seek to continue to increase our Medicaid membership in states in which we currently operate through alliances with key providers, outreach efforts, development and implementation of community-specific products and acquisitions. In 2006, we were awarded two regions in connection with Ohio's statewide restructuring of its Medicaid managed care program, expanding the number of counties we serve from three to 27. We also were awarded a Medicaid Aged, Blind or Disabled, or ABD, contract in four regions in Ohio. In Texas, we expanded our operations to the Corpus Christi market in 2006 and began managing care for SSI recipients in February 2007. We may also increase membership by acquiring Medicaid businesses, contracts and other related assets from our competitors in our existing markets or by enlisting additional providers. For example, in 2005 and 2006, we acquired certain Medicaid-related assets in Ohio.

Diversify Business Lines. We seek to broaden our business lines into areas that complement our existing business to enable us to grow and diversify our revenue. We are constantly evaluating new opportunities for expansion both domestically and abroad. For instance, in October 2006, we commenced operations under our managed care program contracts to provide long-term care services in Arizona, and in January 2006, we completed the acquisition of US Script, a pharmacy benefits manager. We are also considering other premium based or fee-for-service lines of business that would provide additional diversity. We employ a disciplined acquisition strategy that is based on defined criteria including internal rate of return, accretion to earnings per share, market leadership and compatibility with our information systems. We engage our executives in the relevant operational units or functional areas to ensure consistency between the diligence and integration process.

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Address Emerging State Needs. We work to assist the states in which we operate in addressing the operating challenges they face. We seek to assist the states in balancing premium rates, benefit levels, member eligibility, policies and practices, and provider compensation. For example, in 2005 we began performing under our contracts with the State of Arizona to facilitate the delivery of mental health and substance abuse services to behavioral health recipients in Arizona. Effective January 1, 2005, we were awarded a behavioral health contract to serve SCHIP members in Kansas. By helping states structure an appropriate level and range of Medicaid, SCHIP and specialty services, we seek to ensure that we are able to continue to provide those services on terms that achieve targeted gross margins, provide an acceptable return and grow our business.

Develop and Acquire Additional State Markets where Enrollment is Mandated. We continue to leverage our experience to identify and develop new markets by seeking both to acquire existing business and to build our own operations. We expect to focus expansion on states where Medicaid recipients are mandated to enroll in managed care organizations because we believe member enrollment levels are more predictable in these states. For example, effective June 1, 2006, we began managing care for Medicaid and SCHIP members in Georgia.

Leverage Established Infrastructure to Enhance Operating Efficiencies. We intend to continue to invest in infrastructure to further drive efficiencies in operations and to add functionality to improve the service provided to members and other organizations at a low cost. Our centralized functions enable us to add members and markets quickly and economically. For example, during 2005, we opened an additional claims processing facility to accommodate our planned growth initiatives for this centralized function.

Maintain Operational Discipline. We monitor our cost trends, operating performance, regulatory relationships and the Medicaid political environment in our existing markets. We seek to operate in markets that allow us to meet our internal metrics including membership growth, plan size, market leadership and operating efficiency. We may divest contracts or health plans in markets where the state's Medicaid environment, over a long-term basis, does not allow us to meet our targeted performance levels. We use multiple techniques to monitor and reduce our medical costs, including on-site hospital review by staff nurses and involvement of medical management and finance personnel in significant cases. Our health economics unit and health plan controllers evaluate the financial impact of proposed changes in provider relationships. We also conduct monthly reviews of member demographics for each health plan.

Medicaid Managed Care

Health Plans

We have regulated subsidiaries offering healthcare services in each state we serve. The table below provides summary data for the state markets we currently serve:

State	Local Health Plan Name	First Year of Operations Under Centene	Counties Served at December 31, 2006	Market Share(1)	Membership at December 31, 2006
Georgia	Peach State Health Plan	2006	90	30.6%	308,800
Indiana	Managed Health Services	1995	92	33.4%	183,100
New Jersey	University Health Plans	2002	20	8.1%	58,900
Ohio	Buckeye Community Health Plan	2004	27	11.3%	109,200
Texas	Superior Health Plan	1999	217	21.0%	298,500
Wisconsin	Managed Health Services	1984	29	32.9%	164,800

(1) Represents Medicaid and SCHIP membership as of December 31, 2006 as a percentage of total eligible Medicaid and SCHIP members in each state. SSI programs are excluded.

All of our revenue is derived from operations within the United States and its territories. Our managed care subsidiaries in Georgia, Indiana, Kansas, Texas and Wisconsin had revenues from their respective state governments that each exceeded 10% of our consolidated total revenues in 2006. Other financial information about our segments is found in Note 18 of our Notes to Consolidated Financial Statements and "Management's Discussion and Analysis of Financial Condition and Results of Operations" in our Form 10-K for the fiscal year ended December 31, 2006, which is incorporated herein by reference.

Benefits to States

Our ability to establish and maintain a leadership position in the markets we serve results primarily from our demonstrated success in providing quality care while reducing and managing costs, and from our specialized programs in working with state governments. Among the benefits we are able to provide to the states with which we contract are:

- *Significant cost savings compared to state paid reimbursement for services.* We bring bottom-line management experience to our health plans. On the administrative and management side, we bring experience including quality of care improvement methods, utilization management procedures, an efficient claims payment system, and provider performance reporting, as well as managers and staff experienced in using these key elements to improve the quality of and access to care.

- *Data-driven approaches to balance cost and verify eligibility.* Our Medicaid health plans have conducted enrollment processing and activities for state programs since 1984. We ensure effective enrollment procedures that move members into the plan, then educate them and ensure that they receive needed services as quickly as possible. Our IT department has created mapping/translation programs for loading membership and linking membership eligibility status to all of Centene's subsystems.

- *Establishment of realistic and meaningful expectations for quality deliverables.* We have collaborated with state agencies in redefining benefits, eligibility requirements and provider fee schedules with the goal of maximizing the number of uninsured individuals covered through Medicaid and SSI programs.

- *Managed care expertise in government subsidized programs.* Our expertise in Medicaid has helped us establish and maintain strong relationships with our constituent communities of members, providers and state governments. We provide access to services through local providers and staff that focus on the cultural norms of their individual communities. To that end, systems and procedures have been designed to address community-specific challenges through outreach, education, transportation and other member support activities.

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- *Improved medical outcomes.* We have implemented programs developed to achieve savings for state governments and improve medical outcomes for members by reducing inappropriate emergency room use, inpatient days and high cost interventions, as well as by managing care of chronic illness.

- *Timely payment of provider claims.* We are committed to ensuring that our information systems and claims payment systems meet or exceed state requirements. We continuously endeavor to update our systems and processes to improve the timeliness of our provider payments.

- *Cost saving outreach and specialty programs.* Our health plans have adopted a physician-driven approach where network providers are actively engaged in developing and implementing healthcare delivery policies and strategies. This approach is designed to eliminate unnecessary costs, improve services to members and simplify the administrative burdens placed on providers. The combination of a decentralized local approach to health plan operations and a centralized approach to administrative functions such as finance, information systems and claims processing allows us to quickly and economically integrate new business opportunities in both the Medicaid Managed Care and Specialty Services segments.

- *Responsible collection and dissemination of utilization data.* We gather utilization data from multiple sources, allowing for an integrated view of our members' utilization of services. These sources include medical and behavioral health claims and encounter data, pharmacy data, vision and dental vendor claims and authorization data from Care Enhanced Case Management Systems, or CCMS, the authorization and case management system utilized by us to coordinate care.

- *Timely and accurate reporting.* Our information systems have robust reporting capabilities which have been instrumental in identifying the need for new and/or improved healthcare and specialty programs. For state agencies, our reporting capability is instrumental in demonstrating an auditable program.

Member Programs and Services

We recognize the importance of member-focused delivery of quality managed care services. Our locally based staff assist members in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. While covered healthcare benefits vary from state to state, our health plans generally provide the following services:

- primary and specialty physician care
- inpatient and outpatient hospital care
- emergency and urgent care
- prenatal care
- laboratory and x-ray services
- home health and durable medical equipment
- behavioral health and substance abuse services
- 24-hour nurse advice line
- transportation assistance
- vision care
- dental care
- immunizations
- prescriptions and limited over-the-counter drugs

We also provide the following education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services in an efficient manner:

- *CONNECTIONS* is a community face-to-face outreach and education program designed to create a link between the member and the provider and help identify potential challenges or risk elements to a member's health, such as nutritional challenges and health education shortcomings. CONNECTIONS representatives also contact new members by phone or mail to discuss managed care, the Medicaid program and our services. Our CONNECTIONS representatives make home visits, conduct educational programs and represent our health plans at community events such as health fairs.

- *Start Smart For Your Baby* is a prenatal and infant health program designed to increase the percentage of pregnant women receiving early prenatal care, reduce the incidence of low birth weight babies, identify high risk pregnancies, increase participation in the federal Women, Infant and Children program, and increase well-child visits. The program includes risk assessments, education through face-to-face meetings and materials, behavior modification plans, assistance in selecting a provider for the infant and scheduling newborn follow-up visits.

- *EPSDT Case Management* is a preventive care program designed to educate our members on the benefits of Early and Periodic Screening, Diagnosis and Treatment, or EPSDT, services. We have a systematic program of communicating, tracking, outreach, reporting and follow-through that promotes state EPSDT programs.

- *Disease Management Programs* are designed to help members understand their disease and treatment plan and improve their health outcomes in a cost effective manner. These programs address medical conditions that are common within the Medicaid population such as asthma, diabetes and prenatal care. Our Specialty Services segment manages many of our disease management programs. Our SSI program uses a proprietary assessment tool that effectively identifies barriers to care, unmet functional needs, available social supports and the existence of behavioral health conditions that impede a member's ability to maintain a proper health status. Care coordinators develop individual care plans with the member and healthcare providers ensuring the full integration of behavioral, social and acute care services. These care plans, while specific to an SSI member, incorporate "Condition Specific" practices in collaboration with physician partners and community resources.

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Providers

For each of our service areas, we establish a provider network consisting of primary and specialty care physicians, hospitals and ancillary providers. As of December 31, 2006, the health plans we currently serve contracted with the following number of physicians and hospitals:

	Primary Care Physicians	Specialty Care Physicians	Hospitals
Georgia	2,379	7,112	128
Indiana	738	1,422	42
New Jersey	1,732	5,283	73
Ohio	1,026	2,387	35
Texas	5,646	10,487	335
Wisconsin	2,118	4,793	65

Our network of primary care physicians is a critical component in care delivery, management of costs and the attraction and retention of new members. Primary care physicians include family and general practitioners, pediatricians, internal medicine physicians and obstetricians and gynecologists. Specialty care physicians provide medical care to members generally upon referral by the primary care physicians. Specialty care physicians include orthopedic surgeons, cardiologists and otolaryngologists. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services.

Our health plans facilitate access to healthcare services for our members primarily through contracts with our providers. Our contracts with primary and specialty care physicians and hospitals usually are for one to two-year periods and renew automatically for successive one-year terms, but generally are subject to termination by either party upon 90 to 120 days prior written notice. In the absence of a contract, we typically pay providers at state Medicaid reimbursement levels. We pay physicians under a fee-for-service or capitation arrangement.

- Under our fee-for-service contracts with physicians, particularly specialty care physicians, we pay a negotiated fee for covered services. This model is characterized as having no financial risk for the physician. In addition, this model requires management oversight because our total cost may increase as the units of services increase or as more expensive services are replaced for less expensive services. We have prior authorization procedures in place that are intended to make sure that certain high cost diagnostic and other services are medically appropriate.

- Under our capitated contracts, primary care physicians are paid a monthly fee for each of our members assigned to his or her practice and are at risk for all costs related to primary and specialty physician and emergency room services. In return for this payment, these physicians provide all primary care and preventive services, including primary care office visits and EPSDT services. If these physicians also provide non-capitated services to their assigned members, they may receive payment under fee-for-service arrangements at Medicaid rates.

We work with physicians to help them operate efficiently by providing financial and utilization information, physician and patient educational programs and disease and medical management programs. Our programs are also designed to help the physicians coordinate care outside of their offices. In addition, we are governed by state prompt payment policies.

We believe our collaborative approach with physicians gives us a competitive advantage in entering new markets. Our physicians serve on local committees that assist us in implementing preventive care programs, managing costs and improving the overall quality of care delivered to our members. This approach is designed to eliminate unnecessary costs, improve services to our members and simplify the administrative burdens on our providers. It has enabled us to strengthen our provider networks through improved physician recruitment and retention that, in turn, have helped to increase our membership base. The following are among the services we provide to support physicians:

- *Customized Utilization Reports* provide certain of our contracted physicians with information that enables them to run their practices more efficiently and focuses them on specific patient needs. For example, quarterly detail reports update physicians on their status within their risk pools. Equivalency reports provide physicians with financial comparisons of capitated versus fee-for-service arrangements.

- *Case Management Support* helps the physician coordinate specialty care and ancillary services for patients with complex conditions and direct members to appropriate community resources to address both their health and socio-economic needs.

- *Web-based Claims and Eligibility Resources* have been implemented in selected markets to provide physicians with on-line access to perform claims and eligibility inquiries.

- Our contracted physicians also benefit from several of the services offered to our members, including the CONNECTIONS, EPSDT case management and disease management programs. For example, the CONNECTIONS staff facilitates doctor/patient relationships by connecting members with physicians, the EPSDT programs encourage routine checkups for children with their physicians and the disease management programs assist physicians in managing their patients with chronic disease.

Where appropriate, our health plans contract with our specialty services organizations to provide services and programs such as behavioral health, disease management, managed vision, nurse triage, pharmacy benefit management, and treatment compliance. When necessary, we also contract with third-party providers on a negotiated fee arrangement for physical therapy, home healthcare, vision care, diagnostic laboratory tests, x-ray examinations, ambulance services and durable medical equipment. Additionally, we contract with dental vendors in markets where routine dental care is a covered benefit.

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Quality Management

Our medical management programs focus on improving quality of care in areas that have the greatest impact on our members. We employ strategies, including disease management and complex case management, that are adjusted for implementation in our individual markets by a system of physician committees chaired by local physician leaders. This process promotes physician participation and support, both critical factors in the success of any clinical quality improvement program.

We have implemented specialized information systems to support our medical quality management activities. Information is drawn from our data warehouse, clinical databases and our membership and claims processing system, to identify opportunities to improve care and to track the outcomes of the interventions implemented to achieve those improvements. Some examples of these intervention programs include:

- a prenatal case management program aimed at helping women with high-risk pregnancies deliver full-term, healthy infants;
- a program to reduce the number of inappropriate emergency room visits; and
- a disease management program to improve the ability of those with asthma and their families to control their disease and thereby reduce the need for emergency room visits and hospitalizations.

We provide reporting on a regular basis using our data warehouse. State and Health Employer Data and Information Set, or HEDIS, reporting constitutes the core of the information base that drives our clinical quality performance efforts. This reporting is monitored by Plan Quality Improvement Committees and our corporate medical management team.

In an effort to ensure the quality of our provider networks, we undertake to verify the credentials and background of our providers using standards that are supported by the National Committee for Quality Assurance.

Information Technology

The ability to access data and translate it into meaningful information is essential to operating across a multi-state service area in a cost-effective manner. Our centralized information systems which are located in St. Louis, Missouri, support our core processing functions under a set of integrated databases and are designed to be both replicable and scalable to accommodate organic growth and growth from acquisitions. We believe we have the ability to leverage the platform we have developed for our existing states for configuration into new states or health plan acquisitions.

Our integrated approach helps to assure that consistent sources of claim and member information are provided across all of our health plans. Our membership and claims processing system is capable of expanding to support additional members in an efficient manner as needed. We have a disaster recovery and business resumption plan developed and implemented in conjunction with a third party. This plan allows us complete access to the business resumption centers and hot-site facilities provided by the plan.

Specialty Services

Our Specialty Services segment is a key component of our healthcare enterprise and complements our core Medicaid Managed Care business. The specialty services diversify our revenue stream, provide higher quality health outcomes to our membership and others, and assist in controlling costs. Our specialty services are provided primarily through the following interrelated businesses:

- *Behavioral Health.* Cenpatico Behavioral Health manages behavioral healthcare for members via a contracted network of providers. Cenpatico works with providers to determine the best course of treatment for a given diagnosis and helps ensure members and their providers are aware of the full array of services available. Our networks feature a range of services so that patients can be treated at an appropriate level of care. We also run school-based programs in Arizona that focus on students with special needs. We acquired Cenpatico in 2003.

- *Disease Management.* Our disease management providers, AirLogix and Cardium Health, specialize in chronic respiratory disease management and cardiac disease management. Through their specialization in respiratory management, AirLogix uses self-care therapies, in-home interaction and informatics processes to deliver highly effective clinical results, enhanced patient-provider satisfaction and greater cost reductions in respiratory management. We acquired AirLogix in July 2005. Through a people centered, multi-disciplinary and integrated approach, Cardium Health uses primary health coaches, customized care plans, and disease-specific education to assist patients in achieving their health goals and deliver enhanced patient-provider satisfaction and greater cost reductions in chronic disease management. We acquired Cardium Health in May 2006.

- *Long-term Care.* Bridgeway Health Solutions provides long-term care services to the elderly and people with disabilities on SSI that meet income and resources requirements who are at risk of being or are institutionalized. Bridgeway has members in the Maricopa, Yuma and La Paz counties of Arizona. Bridgeway attempts to distinguish itself from other Medicaid and Medicare health plans through ongoing participation with community groups to address situations that might be barriers to quality care and independent living. Bridgeway commenced operations in October 2006.

- *Managed Vision.* OptiCare manages vision benefits for members via a contracted network of providers. OptiCare works with providers to provide a variety of vision plan designs and helps ensure members and their providers are aware of the full array of products and services available. Our networks feature a range of products and services so that patients can be treated at an appropriate level of care. We acquired the managed vision business of OptiCare Health Systems, Inc. in July 2006.

- *Nurse Triage.* NurseWise provides a toll-free nurse triage line 24 hours per day, 7 days per week, 52 weeks per year. Our members call one number and reach customer service representatives and bilingual nursing staff who provide health education, triage advice and offer continuous access to health plan functions. Additionally, our representatives verify eligibility, confirm primary care provider assignments and provide benefit and network referral coordination for members and providers after business hours. Our staff can arrange for urgent pharmacy refills, transportation and qualified behavioral health professionals for crisis stabilization assessments. Call volume is based on membership levels and seasonal variation. NurseWise commenced operations in 1998.

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- *Pharmacy Benefits Management.* US Script is a pharmacy benefits manager that administers pharmacy benefits and processes pharmacy claims via its proprietary claims processing software. US Script has developed and administers a contracted national network of retail pharmacies. We acquired US Script in January 2006.

- *Treatment Compliance. Script*Assist is a treatment compliance program that uses psychological-based tools to predict which patients are likely to be non-compliant regarding taking their medications, and then to motivate those at-risk patients to adhere to their doctors' advice. *Script*Assist uses registered nurses to educate patients about the reasons for the medications they were prescribed, to provide accurate information about side effects and risks of such medications, and to keep the doctors informed of the patients' progress between visits. We acquired *Script*Assist in 2003.

Corporate Compliance

Our Corporate Ethics and Compliance Program was first established in 1998 and provides methods by which we further enhance operations, safeguard against fraud and abuse, improve access to quality care and helps assure that our values are reflected in everything we do.

The two primary standards by which corporate compliance programs in the healthcare industry are measured are the 1991 Federal Organizational Sentencing Guidelines and the "Compliance Program Guidance" series issued by the Office of the Inspector General, or OIG, of the Department of Health and Human Services. Our program contains each of the seven elements suggested by the Sentencing Guidelines and the OIG guidance. These key components are:

- written standards of conduct;

- designation of a corporate compliance officer and compliance committee;

- effective training and education;

- effective lines for reporting and communication;

- enforcement of standards through disciplinary guidelines and actions;

- internal monitoring and auditing; and

- prompt response to detected offenses and development of corrective action plans.

Our internal Corporate Compliance website, accessible by all employees, contains our Business Ethics and Conduct Policy, our Mission, Values and Philosophies and Compliance Programs, a company-wide policy and procedure database and our toll-free hotline to allow employees or other persons to report suspected incidents of fraud, abuse or other violations. The audit committee and the board of directors review a full compliance report, including an incident log, on a quarterly basis.

Competition

We continue to face varying and increasing levels of competition as we expand in our existing service areas or enter new markets as federal regulations require at least two competitors in each service area. Healthcare reform proposals may cause a number of commercial managed care organizations to decide to enter or exit the Medicaid market.

In our business, our principal competitors for state contracts, members and providers consist of the following types of organizations:

- *Medicaid Managed Care Organizations* focus solely on providing healthcare services to Medicaid recipients. Many of these operate in one city or state and are owned by providers, primarily hospitals.

- *National and Regional Commercial Managed Care Organizations* have Medicaid members in addition to members in private commercial plans. Some of these organizations offer a range of specialty services including pharmacy benefits management, behavioral health management, disease management, and nurse triage call support centers.

- *Primary Care Case Management Programs* are programs established by the states through contracts with primary care providers. Under these programs, physicians provide primary care services to Medicaid recipients, as well as limited medical management oversight.

We compete with other managed care organizations and specialty companies for state contracts. In order to grant a contract, state governments consider many factors. These factors include quality of care, financial requirements, an ability to deliver services and establish provider networks and infrastructure. In addition, our specialty companies also compete with other providers, such as disease management companies and pharmacy benefits managers for non-governmental contracts.

We also compete to enroll new members and retain existing members. People who wish to enroll in a managed healthcare plan or to change healthcare plans typically choose a plan based on the quality of care and services offered, ease of access to services, a specific provider being part of the network and the availability of supplemental benefits. In certain markets, where recipients select a physician instead of a health plan, we are able to grow our membership by adding new physicians to our provider base.

We also compete with other managed care organizations to enter into contracts with physicians, physician groups and other providers. We believe the factors that providers consider in deciding whether to contract with us include existing and potential member volume, reimbursement rates, medical management programs, speed of reimbursement and administrative service capabilities. See “Risk Factors — Competition may limit our ability to increase penetration of the markets that we serve.”

Regulation

Our healthcare and specialty operations are regulated at both state and federal levels. Government regulation of the provision of healthcare products and services is a changing area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules also may occur periodically.

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Our regulated subsidiaries are licensed to operate as health maintenance organizations and/or insurance companies in their respective states. In each of the jurisdictions in which we operate, we are regulated by the relevant health, insurance and/or human services departments that oversee the activities of managed care organizations providing or arranging to provide services to Medicaid enrollees.

The process for obtaining authorization to operate as a managed care organization is complex and requires demonstration to the regulators of the adequacy of the health plan's organizational structure, financial resources, utilization review, quality assurance programs, complaint procedures, provider network adequacy and procedures for covering emergency medical conditions. Under both state managed care organization statutes and state insurance laws, our health plan subsidiaries must comply with minimum statutory capital requirements and other financial requirements, such as deposit and reserve requirements. Insurance regulations may also require prior state approval of acquisitions of other managed care organizations' businesses and the payment of dividends, as well as notice for loans or the transfer of funds. Our subsidiaries are also subject to periodic reporting requirements. In addition, each health plan must meet criteria to secure the approval of state regulatory authorities before implementing operational changes, including the development of new product offerings and, in some states, the expansion of service areas.

States have adopted a number of regulations that may affect our business and results of operations. These regulations in certain states include:

- premium and maintenance taxes;
- stringent prompt-pay laws;
- requirements of National Provider Identifier numbers on claim submittals;
- disclosure requirements regarding provider fee schedules and coding procedures; and
- programs to monitor and supervise the activities and financial solvency of provider groups.

State Contracts

In order to be a Medicaid Managed Care organization in each of the states in which we operate, we must operate under a contract with the state's Medicaid agency. States generally use either a formal proposal process, reviewing a number of bidders, or award individual contracts to qualified applicants that apply for entry to the program. We receive monthly payments based on specified capitation rates determined on an actuarial basis. These rates differ by membership category and by state depending on the specific benefits and policies adopted by each state.

Our contracts with the states and regulatory provisions applicable to us generally set forth the requirements for operating in the Medicaid sector, including provisions relating to:

- eligibility, enrollment and disenrollment processes;
- covered services;
- eligible providers;
- subcontractors;
- record-keeping and record retention;

- periodic financial and informational reporting;
- quality assurance;
- health education and wellness and prevention programs;
- timeliness of claims payment;
- financial standards;
- safeguarding of member information;
- fraud and abuse detection and reporting;
- grievance procedures; and
- organization and administrative systems.

A health plan's compliance with these requirements is subject to monitoring by state regulators and by CMS. A health plan is also subject to periodic comprehensive quality assurance evaluations by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan. A health plan must also submit reports to various regulatory agencies, including quarterly and annual statutory financial statements and utilization reports.

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The table below sets forth the term of our state contracts and provides details regarding related renewal or extension and termination provisions as of December 31, 2006.

State Contract	Expiration Date	Renewal or Extension by the State	Termination by the State
Arizona — Behavioral Health	June 30, 2008	May be extended for up to two additional years.	May be terminated for convenience or an event of default.
Arizona — Long-term Care	September 30, 2009	May be extended for up to two additional years.	May be terminated for convenience or an event of default.
Georgia	June 30, 2007	Renewable for five additional one-year terms.	May be terminated for an event of default or significant changes in circumstances.
Indiana	December 31, 2010	May be extended for up to two additional years.	May be terminated for convenience or an event of default.
Kansas —Behavioral Health	June 30, 2008	May be extended with four one-year renewal options.	May be terminated for cause, or without cause for lack of funding.
Missouri	June 30, 2007		