CENTENE CORP
Form 10-K
February 23, 2009

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)
T ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2008

or

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

For the transition period from to

Commission file number: 001-31826

Centene Corporation
(Exact name of registrant as specified in its charter)

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

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

Securities registered pursuant to Section 12(b) of the Act:

Common Stock, $0.001 Par Value	New York Stock Exchange
Title of Each Class	Name of Each Exchange on Which Registered

Securities registered pursuant to Section 12(g) of the Act:
None
(Title of Each Class)

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.
Yes T No £

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.
Yes £ No T

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. T

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filed, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer" and "small reporting company" in Rule 12b-2 of the Exchange Act. Large accelerated filer T Accelerated filer £ Non-accelerated filer £ (do not check if a smaller reporting company) Smaller reporting company £

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 30, 2008, was $713.9 million.

As of February 6, 2009, the registrant had 43,012,236 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2009 annual meeting of stockholders are incorporated by reference in Part I, Item 1 and Part III, Items 10, 11, 12, 13 and 14.

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Our trademark, service marks and trade names referred to in this filing include Absolute Total Care, Bridgeway Health Solutions, Buckeye Community Health Plan, Celtic Insurance Company, Cenpatico Behavioral Health, Cenpatico Behavioral Health of Arizona, Centene, Managed Health Services, MemberConnections, Nurse Response, NurseWise, Nurtur, OptiCare, Peach State Health Plan, PhyTrust, ScriptAssist, Smart Start For Your Baby, Sunshine State Health Plan, Superior HealthPlan, Total Carolina Care, US Script and University Health Plans, among others.

FORWARD-LOOKING STATEMENTS

All statements, other than statements of current or historical fact, contained in this filing are forward-looking statements. We have attempted to identify these statements by terminology including "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "target," "goal," "may," "will," "should," "can," "continue" and other similar words or expressions in connection with, among other things, any discussion of future operating or financial performance. In particular, these statements include statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, including those entitled "Management's Discussion and Analysis of Financial Condition and Results of Operations," Part I, Item 1A. "Risk Factors," and Part I, Item 3 "Legal Proceedings." Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, including economic, regulatory, competitive and other factors that may cause our or our industry's actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

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

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

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

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PART I

Item 1. Business

OVERVIEW

We are a multi-line healthcare enterprise operating 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, Foster Care, Medicare Special Needs Plans and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program, or collectively ABD. Medicaid currently accounts for 73% of our membership, while SCHIP (also including Foster Care) and ABD (also including Medicare) account for 22% and 5%, respectively. Our Specialty Services segment provides specialty services, including behavioral health, individual health insurance, life and health management, long-term care programs, managed vision, nurse triage, and pharmacy benefits management to state programs, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries. Our Specialty Services segment also provides a full range of healthcare solutions for the rising number of uninsured Americans.

During 2008, we announced our intention to sell certain assets of University Health Plans, Inc. This pending sale is discussed in detail under the caption "Discontinued Operations" under "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations." Accordingly, our New Jersey health plan operations are presented as discontinued operations for all periods in our consolidated financial statements beginning with this Annual Report on Form 10-K. The following discussion and analysis is presented primarily in the context of continuing operations unless otherwise identified. For the year ended December 31, 2008, our revenues, total cash flow from operations, and net earnings were $3.4 billion, $222.0 million and $84.2 million, respectively.

Our Medicaid Managed Care segment membership totaled approximately 1.2 million as of December 31, 2008, while our Specialty Services segment external membership totaled 163,100. We currently have health plan subsidiaries offering healthcare services in Arizona, Georgia, Indiana, Ohio, South Carolina, Texas and Wisconsin, as well as New Jersey. Additionally, effective in July 2007, we acquired a minority interest in Access Health Solutions, LLC, or Access, which provides managed care on a non-risk basis for Medicaid recipients in Florida. In February 2009, we began operations in Florida through our wholly-owned subsidiary, Sunshine State Health Plan, Inc. 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 health plans, including provider and member services, enables us to provide accessible, quality, culturally-sensitive healthcare coverage to our communities. Our health 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. Our corporate office is located at 7711 Carondelet Avenue, St. Louis, Missouri 63105, and our telephone number is (314) 725-4477. 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, Foster Care and ABD programs. The federal Centers for Medicare and Medicaid Services, or CMS, estimated the total Medicaid market was approximately $311 billion in 2006, and estimate the market will grow to $720 billion by 2017. According to the most recent information provided by the Kaiser Commission on Medicaid and the Uninsured, Medicaid spending increased by 5.3% in fiscal 2008 and states appropriated an increase of 5.8% for Medicaid in fiscal 2009 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. Many states have selected Medicaid managed care as a means of delivering quality healthcare and controlling costs, including states that automatically enroll Medicaid recipients who don't select a health plan. We refer to these states as mandated managed care states. 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, ABD covers low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries represent a growing portion of all Medicaid recipients. In addition, ABD 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 CMS, there were approximately seven million dual eligible enrollees in 2006. 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 ABD and long-term care programs, and beginning in 2008, through Special Needs Plans.

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. Additionally, a number of states are designing programs to cover the rising number of uninsured Americans. The US Census Bureau estimated there were 45.7 million Americans in 2007 that lacked health insurance. 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 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 uninsured population and the Medicaid, SCHIP, Foster Care and ABD populations. We believe our approach and strategy enable us to be a growing participant in this market.

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 offerings. We entered the Wisconsin market in 1984, the Indiana market in 1995, the Texas market in 1999, the Ohio market in 2004, the Georgia market in 2006, and the South Carolina market in 2007. We have increased our membership through participation in new programs in existing states. For example, in 2008, we began operations in the Texas Foster Care program and began serving Acute Care members in the Yavapai county of Arizona. We have also increased membership by acquiring Medicaid businesses, contracts and other related assets from competitors in existing markets, most recently in South Carolina in 2007. Our Medicaid Managed Care membership totaled approximately 1.2 million as of December 31, 2008. For the year ended December 31, 2008, we had revenues of $3.4 billion, representing a 40% Compound Annual Growth Rate, or CAGR, since the year ended December 31, 2004. We generated total cash flow from operations of $222.0 million and net earnings of $84.2 million for the year ended December 31, 2008.

- 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, Foster Care and ABD and expand these types of benefits offered. Our approach is to accomplish this while maintaining adequate levels of provider compensation and protecting our profitability.

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- 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, individual health insurance, life and health management, long-term care programs, managed vision, nurse triage and pharmacy benefits management. Through the utilization of a multi-business line approach, we are able to diversify our revenues 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. We continue to develop our specialized information systems which allow us to support our core processing functions under a set of integrated databases, 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.

OUR BUSINESS STRATEGY

Our objective is to become the leading multi-line healthcare enterprise focusing on the uninsured population and state funded healthcare initiatives. 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 ABD contract in four regions in Ohio. In Texas, we expanded our operations to the Corpus Christi market in 2006, began managing care for ABD recipients in February 2007 and began operations in the Foster Care program in April 2008. In Arizona, we began serving members within a long-term care plan in 2006 and within an acute care plan in 2008. In 2008, we began serving Medicare members within Special Needs Plans in Arizona, Ohio, Texas and Wisconsin. 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 July 2008, we completed the acquisition of Celtic Insurance Company, or Celtic, a national individual health insurance provider, 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.

- 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 2008, we began operating under a contract with the Texas Health and Human Services Commission for Comprehensive Health Care for Children in Foster Care, a new statewide program providing managed care services to participants in the Texas Foster Care program. 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. 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 in 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. In addition, we focus our attention on states converting to a full-risk, managed care model. For example, in 2007, we entered the South Carolina market and we participated in the state's conversion to at-risk managed care. In February 2009, we began managed care operations in Florida through conversion of members in certain counties from Access Health Solutions to at-risk managed care in Sunshine State Health Plan, through our new state contract.

- 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.

- 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 financial management teams 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 the Company	Counties Served at December 31, 2008	Market Share (1)	Membership at December 31, 2008
Florida (2)	Sunshine State Health Plan	2009	—	—	—
Georgia	Peach State Health Plan	2006	90	29.4%	288,300
Indiana	Managed Health Services	1995	92	30.0%	175,300
New Jersey (3)	University Health Plans	2002	20	6.7%	55,200
Ohio	Buckeye Community Health Plan	2004	43	9.9%	133,400
South Carolina	Absolute Total Care	2007	42	9.7%	31,300
Texas	Superior HealthPlan	1999	242	23.4%	431,700
Wisconsin	Managed Health Services	1984	33	15.8%	124,800

(1) Represents Medicaid and SCHIP membership as of December 31, 2008 as a percentage of total eligible Medicaid and SCHIP members in each state. ABD programs are excluded.

(2) We began membership operations in Florida in February 2009.

(3) In November 2008, we announced our intention to sell University Health Plans. As a result, this plan is presented as discontinued operations in our consolidated financial statements, however as of December 31, 2008, the plan was still operated by Centene Corporation.

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All of our revenue is derived from operations within the United States and its territories. We generally receive a fixed premium per member per month pursuant to our state contracts. Our medical costs have a seasonality component due to cyclical illness, for example cold and flu season, resulting in higher medical expenses beginning in the fourth quarter and continuing throughout the first quarter of each year. Our managed care subsidiaries in Georgia, Ohio, and Texas had revenues from their respective state governments that each exceeded 10% of our consolidated total revenues in 2008. Other financial information about our segments is found in Note 20, Segment Information, of our Notes to Consolidated Financial Statements and "Management's Discussion and Analysis of Financial Condition and Results of Operations" included elsewhere in this Annual Report on Form 10-K.

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 seek to ensure effective enrollment procedures that move members into the plan, then educate them and ensure 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 individuals covered through Medicaid, SCHIP, Foster Care and ABD 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.

- 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.

Ÿ 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, vision and behavioral health claims and encounter data, pharmacy data, dental vendor claims and authorization data from the authorization and case management system utilized by us to coordinate care.

Ÿ Timely and accurate reporting. Our information systems have 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 important 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:

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

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

Ÿ MemberConnections 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. MemberConnections representatives also contact new members by phone or mail to discuss managed care, the Medicaid program and our services. Our MemberConnections representatives make home visits, conduct educational programs and represent our health plans at community events such as health fairs.

Ÿ 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, prevent hospital admissions in the first year of life 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.

Ÿ 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.

Ÿ

Life and Health Management Programs are designed to help members understand their disease and treatment plan and improve their wellness in a cost effective manner. These programs address medical conditions that are common within the Medicaid population such as asthma, diabetes and pregnancy. Our Specialty Services segment manages many of our life and health management programs. Our ABD 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 ABD 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, 2008, the health plans we operated contracted with the following number of physicians and hospitals:

	Primary Care Physicians	Specialty Care Physicians	Hospitals
Georgia	3,256	9,620	151
Indiana	914	3,209	79
New Jersey (1)	1,204	4,362	63
Ohio	2,200	8,396	122
South Carolina	592	1,095	19
Texas	7,633	18,373	382
Wisconsin	1,857	4,985	61
Total	17,656	50,040	877

(1) In November 2008, we announced our intention to sell University Health Plans. As a result, this plan is presented as discontinued operations in our consolidated financial statements, however as of December 31, 2008, the plan was still operated by Centene Corporation.

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, but are not limited to, 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, capitation arrangement, or risk-sharing 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 replace 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 associated with 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 standard Medicaid rates.

- Under risk-sharing arrangements, physicians are paid under a capitated or fee-for-service arrangement. The arrangement, however, contains provisions for additional bonus to the physicians or reimbursement from the physicians based upon cost and quality factors. We often refer to these arrangements as Model 1 contracts.

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, while also simplifying the administrative burdens on our providers. This approach 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 MemberConnections, EPSDT case management and health management programs. For example, the MemberConnections staff facilitates doctor/patient relationships by connecting members with physicians, the EPSDT programs encourage routine checkups for children with their physicians and the health 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, health 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, 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.

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 health 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:

- Appropriate leveling of care for neonatal intensive care unit (NICU) hospital admissions, other inpatient hospital admissions, and observation admissions, in accordance with Interqual criteria;
- tightening of our pre-authorization list and more stringent review of durable medical equipment and injectibles.
- emergency department (ED) program designed to collaboratively work with hospitals to steer non-emergency care away from the costly ED setting (through patient education, on-site alternative urgent care settings, etc.);
- increase emphasis on case management and clinical rounding where case managers are nurses or social workers who are employed by the health plan to assist selected patients with the coordination of healthcare services in order to meet a patient's specific healthcare needs;
- incorporation of disease management, which is a comprehensive, multidisciplinary, collaborative approach to chronic illnesses such as asthma and diabetes;
- Smart Start For Your Baby, a prenatal case management program aimed at helping women with high-risk pregnancies deliver full-term, healthy infants.

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.

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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 continue to enhance our systems in order 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. 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. Specialty services diversifies our revenue stream, provides higher quality health outcomes to our membership and others, and assists in controlling costs. Our specialty services are provided primarily through the following businesses:

Ÿ Behavioral Health. Cenpatico Behavioral Health, or Cenpatico, 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.

Ÿ Individual Health Insurance. Our individual health insurance company, Celtic, is a national healthcare provider offering high-quality, affordable health insurance to individual customers and their families. Sold online and through independent insurance agents nationwide, Celtic's portfolio of major medical plans is designed to meet the diverse needs of the uninsured at all budget and benefit levels. Celtic also offers a standalone guaranteed-issue medical conversion program to self-funded employer groups, stop-loss and fully-insured group carriers, managed care plans, and HMO reinsurers. We acquired Celtic in 2008.

Ÿ Life and Health Management. Our life and health management company, Nurtur Health specializes in implementing life and health management programs that encourage healthy behaviors, promote healthier workplaces, improve productivity and reduce healthcare costs. Specific focuses include chronic respiratory health management, cardiac health management, and work/life management. Through its specialization in respiratory management, Nurtur Health 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. Nurtur Health was formed in December 2007 through the combination of three entities we acquired from July 2005 through November 2007.

Ÿ Long-term Care and Acute Care. Bridgeway Health Solutions, or Bridgeway, provides long-term care services to the elderly and people with disabilities on ABD 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 participates with community groups to address situations that might be barriers to quality care and independent living. Bridgeway commenced long-term care operations in October 2006. Bridgeway also provides acute care services to members in the Yavapai county of Arizona. These services include emergency and

physician services, limited dental and rehabilitative services and other maternal and child health services. Bridgeway commenced acute care operations in October 2008.

Ÿ 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.

Ÿ Nurse Triage. NurseWise and Nurse Response provide 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 bilingual customer service representatives and 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.

Ÿ 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.

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 help 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:

Ÿ written standards of conduct;
Ÿ designation of a corporate compliance officer and compliance committee;
Ÿ effective training and education;
Ÿ effective lines for reporting and communication;
Ÿ enforcement of standards through disciplinary guidelines and actions;
Ÿ internal monitoring and auditing; and
Ÿ 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 compliance report 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:

Ÿ Medicaid Managed Care Organizations focus on providing healthcare services to Medicaid recipients. These organizations consist of national and regional organizations, as well as smaller organizations that operate in one city or state and are owned by providers, primarily hospitals.

Ÿ 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, health management, and nurse triage call support centers.

Ÿ 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, individual health insurance companies, and pharmacy benefits managers for non-governmental contracts.

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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.

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, as well as our specialty companies, must comply with minimum statutory capital requirements or 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 and individual health insurance provider 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:

- Ÿ premium and maintenance taxes;
- Ÿ stringent prompt-pay laws;
- Ÿ requirements of National Provider Identifier numbers on claim submittals;
- Ÿ disclosure requirements regarding provider fee schedules and coding procedures; and
- Ÿ 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 or individual health insurance providers' 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 or individual health insurance provider 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 January 1, 2009.

State Contract	Expiration Date	Renewal or Extension by the State	Termination by the State
Arizona – Acute Care	September 30, 2011	May be extended for up to two additional one-year terms.	May be terminated for convenience or an event of default.
Arizona – Behavioral Health	June 30, 2009	May be extended for up to one additional year.	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, an event of default or lack of funding.
Arizona – Special Needs Plan (Medicare)	December 31, 2009	Renewable annually for successive 12-month periods.	May be terminated by an event of default.
Florida - Medicaid	August 31, 2009	Renewable through the state’s recertification process.	May be terminated for an event of default or lack of federal funding.
Georgia – Medicaid & SCHIP	June 30, 2009	Renewable for three additional one-year terms.	May be terminated for an event of default or significant changes in circumstances.
Indiana – Medicaid & SCHIP	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, 2009	May be extended with three one-year renewal options.	May be terminated for cause, or without cause for lack of funding.
New Jersey – Medicaid, SCHIP & ABD	June 30, 2009	Renewable annually for successive 12-month periods.	May be terminated for convenience or an event of default.
Ohio – Medicaid & SCHIP	June 30, 2009	Renewable annually for successive 12-month periods.	May be terminated for an event of default.
Ohio – Aged, Blind or Disabled (ABD)	June 30, 2009	Renewable annually for successive 12-month	May be terminated for an event of default.

		periods.	
Ohio – Special Needs Plan (Medicare)	December 31, 2009	Renewable annually for successive 12-month periods.	May be terminated by an event of default.
South Carolina – Medicaid & ABD	March 31, 2009	Renewable annually for successive 12-month periods.	May be terminated for convenience or an event of default.
South Carolina – SCHIP	March 31, 2009	May be extended for up to one additional year.	May be terminated for convenience, an event of default or lack of federal funding.
Texas –Medicaid, SCHIP & ABD	August 31, 2010	May be extended for up to four additional years.	May be terminated for convenience, an event of default or lack of federal funding.
Texas – Exclusive Provider Organization (SCHIP)	August 31, 2009	May be extended for up to one additional year.	May be terminated upon any event of default or in the event of lack of state or federal funding.
Texas – Foster Care	August 31, 2010	May be extended for up to four and a half additional years.	May be terminated for convenience, an event of default, or non-appropriation of funds.
Texas – Special Needs Plan (Medicare)	December 31, 2009	Renewable annually for successive 12-month periods.	May be terminated by an event of default.
Wisconsin –Medicaid & ABD	December 31, 2009	May be extended for up to one additional year.	May be terminated if a change in state or federal laws, rules or regulations materially affects either party's right or responsibilities or for an event of default or lack of funding.
Wisconsin – Network Health Plan Subcontract	December 31, 2011	Renews automatically for successive five-year terms.	May be terminated upon two-years notice prior to the end of the then current term or if a change in state or federal laws, rules or regulations materially affects either party's rights or responsibilities under the

			contract, or if Network Health Plan's contract with the State is terminated.
Wisconsin – Special Needs Plan (Medicare)	December 31, 2009	Renewable annually for successive 12-month periods.	May be terminated by an event of default.

HIPAA

In 1996, Congress enacted the Health Insurance Portability and Accountability Act of 1996, or HIPAA. The Act is designed to improve the portability and continuity of health insurance coverage and simplify the administration of health insurance claims. Among the main requirements of HIPAA are standards for the processing of health insurance claims and related transactions.

The regulation's requirements apply to transactions conducted using "electronic media." Since "electronic media" is defined broadly to include "transmissions that are physically moved from one location to another using magnetic tape, disk or compact disk media," many communications are considered to be electronically transmitted. Under the HIPAA regulations, health plans are required to have the capacity to accept and send all covered transactions in a standardized electronic format. Penalties can be imposed for failure to comply with these requirements.

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HIPAA regulations also protect the privacy of medical records and other personal health information maintained and used by healthcare providers, health plans and healthcare clearinghouses. We have implemented processes, policies and procedures to comply with the HIPAA privacy regulations, including education and training for employees. In addition, the corporate privacy officer and health plan privacy officials serve as resources to employees to address any questions or concerns they may have. Among numerous other requirements, the privacy regulations:

- limit certain uses and disclosures of private health information, and require patient authorizations for such uses and disclosures of private health information;
- guarantee patients rights to access their medical records and to know who else has accessed them;
- limit most disclosure of health information to the minimum needed for the intended purpose;
- establish procedures to ensure the protection of private health information;
- authorize access to records by researchers and others; and
- impose criminal and civil sanctions for improper uses or disclosures of health information.

The preemption provisions of HIPAA provide that the federal standards will not preempt state laws that are more stringent than the related federal requirements. In addition, the Secretary of HHS may grant exceptions allowing state laws to prevail if one or more of a number of conditions are met, including but not limited to the following:

- the state law is necessary to prevent fraud and abuse associated with the provision of and payment for healthcare;
- the state law is necessary to ensure appropriate state regulation of insurance and health plans;
- the state law is necessary for state reporting on healthcare delivery or costs; or
- the state law addresses controlled substances.

In 2003, HHS published final regulations relating to the security of electronic individually identifiable health information. Compliance with these regulations was required by April 2005. These regulations require healthcare providers, health plans and healthcare clearinghouses to implement administrative, physical and technical safeguards to ensure the privacy and confidentiality of such information when it is electronically stored, maintained or transmitted through such devices as user authentication mechanisms and system activity audits. In addition, numerous states have adopted personal data security laws that provide for, among other things, private rights of action for breaches of data security and mandatory notification to persons whose identifiable information is obtained without authorization.

Patients' Rights Legislation

The United States Senate and House of Representatives passed different versions of patients' rights legislation in 2001. Both versions included provisions that specifically apply protections to participants in federal healthcare programs, including Medicaid beneficiaries. Although no such federal legislation has been enacted, patients' rights legislation is frequently proposed in Congress. If enacted, this type of legislation could expand our potential exposure to lawsuits and increase our regulatory compliance costs. Depending on the final form of any enacted patients' rights legislation, such legislation could, among other things, expose us to liability for economic and punitive damages for making determinations that deny benefits or delay beneficiaries' receipt of benefits as a result of our medical necessity or other coverage determinations. We cannot predict when or whether patients' rights legislation will be enacted into law or, if enacted, what final form such legislation might take.

Other Fraud and Abuse Laws

Investigating and prosecuting healthcare fraud and abuse became a top priority for law enforcement entities in the last decade. The focus of these efforts has been directed at participants in public government healthcare programs such as Medicaid. The laws and regulations relating to Medicaid fraud and abuse and the contractual requirements applicable

to health plans participating in these programs are complex and changing and may require substantial resources.

EMPLOYEES

As of December 31, 2008, we had approximately 3,600 employees. None of our employees are represented by a union. We believe our relationships with our employees are good.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following table sets forth information regarding our executive officers, including their ages, at January 31, 2009:

Name	Age	Position
Michael F. Neidorff	66	Chairman and Chief Executive Officer
Mark W. Eggert	47	Executive Vice President, Health Plan Business Unit
Carol E. Goldman	51	Executive Vice President and Chief Administrative Officer
Cary D. Hobbs	41	Senior Vice President, Business Management and Integration
Jesse N. Hunter	33	Executive Vice President, Corporate Development
Donald G. Imholz	56	Senior Vice President and Chief Information Officer
Edmund E. Kroll	49	Senior Vice President, Finance and Investor Relations
Frederick J. Manning	61	Executive Vice President, Celtic Insurance Company
William N. Scheffel	55	Executive Vice President, Specialty Business Unit
Jeffrey A. Schwaneke	33	Vice President, Corporate Controller and Chief Accounting Officer
Eric R. Slusser	48	Executive Vice President, Chief Financial Officer and Treasurer
Keith H. Williamson	56	Senior Vice President, General Counsel and Secretary

Michael F. Neidorff. Mr. Neidorff has served as our Chairman and Chief Executive Officer since May 2004. From May 1996 to May 2004, Mr. Neidorff served as President, Chief Executive Officer and as a member of our board of directors. From 1995 to 1996, Mr. Neidorff served as a Regional Vice President of Coventry Corporation, a publicly-traded managed care organization, and as the President and Chief Executive Officer of one of its subsidiaries, Group Health Plan, Inc. From 1985 to 1995, Mr. Neidorff served as the President and Chief Executive Officer of Physicians Health Plan of Greater St. Louis, a subsidiary of United Healthcare Corp., a publicly-traded managed care organization now known as UnitedHealth Group Incorporated. Mr. Neidorff also serves as a director of Brown Shoe

Company, Inc., a publicly-traded footwear company with global operations.

Mark W. Eggert. Mr. Eggert has served as our Executive Vice President, Health Plan Business Unit since November 2007. From January 1999 to November 2007, Mr. Eggert served as the Associate Vice Chancellor and Deputy General Counsel at Washington University, where he oversaw the legal affairs of the School of Medicine.

Carol E. Goldman. Ms. Goldman has served as Executive Vice President and Chief Administrative Officer since June 2007. From July 2002 to June 2007, she served as our Senior Vice President, Chief Administrative Officer. From September 2001 to July 2002, Ms. Goldman served as our Plan Director of Human Resources. From 1998 to August 2001, Ms. Goldman was Human Resources Manager at Mallinckrodt Inc., a medical device and pharmaceutical company.

Cary D. Hobbs. Ms. Hobbs has served as our Senior Vice President, Business Management and Integration since September 2007. She served as our Senior Vice President of Strategy and Business Implementation from January 2004 to September 2007. She served as our Vice President of Strategy and Business Implementation from September 2002 to January 2004 and as our Director of Business Implementation from 1997 to August 2002.

Jesse N. Hunter. Mr. Hunter has served as our Executive Vice President, Corporate Development since April 2008. He served as our Senior Vice President, Corporate Development from April 2007 to April 2008. He served as our Vice President, Corporate Development from December 2006 to April 2007. From October 2004 to December 2006, he served as our Vice President, Mergers & Acquisitions. From July 2003 until October 2004, he served as the Director of Mergers & Acquisitions and from February 2002 until July 2003, he served as the Manager of Mergers & Acquisitions.

Donald G. Imholz. Mr. Imholz has served as our Senior Vice President and Chief Information Officer since September 2008. From January 2008 to September 2008, Mr. Imholz was an independent consultant working for clients across a variety of industries. From January 1975 to January 2008, Mr. Imholz was with The Boeing Company and served as Vice President of Information Technology from 2002 to January 2008. In that role, Mr. Imholz was responsible for all application development and support worldwide.

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Edmund E. Kroll. Mr. Kroll has served as our Senior Vice President, Finance and Investor Relations since May 2007. From June 1997 to November 2006, Mr. Kroll served as Managing Director at Cowen and Company LLC, where his research coverage focused on the managed care industry, including the Company.

Frederick J. Manning. Mr. Manning has served as our Executive Vice President, Celtic Insurance Company since July 2008. From 1978 to July 2008, Mr. Manning served as Chief Executive Officer and Chairman of the Board of Celtic Insurance Company.

William N. Scheffel. Mr. Scheffel has served as our Executive Vice President, Specialty Business Unit since June 2007. From May 2005 to June 2007, he served as our Senior Vice President, Specialty Business Unit. From December 2003 until May 2005, he served as our Senior Vice President and Controller. From July 2002 to October 2003, Mr. Scheffel was a partner with Ernst & Young LLP. From 1975 to July 2002, Mr. Scheffel was with Arthur Andersen LLP.

Jeffrey A. Schwaneke. Mr. Schwaneke has served as our Vice President, Corporate Controller since July 2008 and Chief Accounting Officer since September 2008. He previously served as Vice President, Controller and Chief Accounting Officer at Novelis Inc. from October 2007 to July 2008, and Assistant Corporate Controller from May 2006 to September 2007. Mr. Schwaneke served as Segment Controller for SPX Corporation from January 2005 to April 2006. Mr. Schwaneke served as Corporate Controller at Marley Cooling Technologies, a segment of SPX Corporation, from March 2004 to December 2004 and Director of Financial Reporting from November 2002 to February 2004.

Eric R. Slusser. Mr. Slusser has served as our Executive Vice President and Chief Financial Officer since July 2007 and as our Treasurer since February 2008. Mr. Slusser served as Executive Vice President of Finance, Chief Accounting Officer and Controller of Cardinal Health, Inc. from May 2006 to July 2007 and as Senior Vice President, Chief Accounting Officer and Controller of Cardinal Health, Inc. from May 2005 to May 2006. Mr. Slusser served as Senior Vice President-Chief Accounting Officer and Controller for MCI, Inc. from November 2003 to May 2005, as Corporate Controller for AES (an electric power generation and transmission company) from May 2003 to November 2003, and as Vice President-Controller from January 1996 to May 2003 for Sprint PCS.

Keith H. Williamson. Mr. Williamson has served as our Senior Vice President, General Counsel since November 2006 and as our Secretary since February 2007. From 1988 until November 2006, he served at Pitney Bowes Inc. in various legal and executive roles, the last seven years as a Division President. Mr. Williamson also serves as a director of PPL Corporation, a publicly-traded energy and utility holding company.

Available Information

We are subject to the reporting and information requirements of the Securities Exchange Act of 1934, as amended (Exchange Act) and, as a result, we file periodic reports and other information with the Securities and Exchange Commission, or SEC. We make these filings available on our website free of charge, the URL of which is http://www.centene.com, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. The SEC maintains a website (http://www.sec.gov) that contains our annual, quarterly and current reports and other information we file electronically with the SEC. You can read and copy any materials we file with the SEC at the SEC's Public Reference Room at 100 F Street, N.E., Room 1850, Washington, D.C. 20549. You may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. Information on our website does not constitute part of this Annual Report on Form 10-K.

Item 1A. Risk Factors

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

Risks Related to Being a Regulated Entity

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

Most of our revenues come from Medicaid, SCHIP and ABD 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 ABD funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Additionally, state and federal entities may make changes to the design of their Medicaid programs resulting in the cancellation or modification of these programs.

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

The American Reinvestment and Recovery Act of 2009, which was signed into law on February 17, 2009, provides $87 billion in additional federal Medicaid funding for states' Medicaid expenditures between October 1, 2008 and December 31, 2010. Under this Act, states meeting certain eligibility requirements will temporarily receive additional money in the form of an increase in the federal medical assistance percentage (FMAP). Thus, for a limited period of time, the share of Medicaid costs that are paid for by the federal government will go up, and each state's share will go down. We cannot predict whether states are, or will remain, eligible to receive the additional federal Medicaid funding, or whether the states will have sufficient funds for their Medicaid programs.

States also periodically consider reducing or reallocating the amount of money they spend for Medicaid, SCHIP, Foster Care and ABD. In recent years, the majority of states have implemented measures to restrict Medicaid, SCHIP, Foster Care and ABD costs and eligibility.

Changes to Medicaid, SCHIP, Foster Care and ABD 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 these programs, all of which could have a negative impact on our business. We believe that reductions in Medicaid, SCHIP, Foster Care and ABD 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 or states face shortfalls, our business could suffer.

Federal support for SCHIP has been authorized through 2013. We cannot be certain that SCHIP will be reauthorized when current funding expires in 2013, and if it is, what changes might be made to the program following reauthorization. Thus, we cannot predict the impact that reauthorization will have 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. Because of funding caps, there is a risk that these states could experience shortfalls in future years, which could have an impact on our ability to receive amounts owed to us from states in which we have SCHIP contracts.

If any of our state 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 ABD. 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 or renew between March 31, 2009 and December 31, 2010. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. For example, on August 25, 2006, we received notification from the Kansas Health Policy Authority that FirstGuard Health Plan Kansas, Inc.'s contract with the State would not be renewed or extended, and as a result, our contract ended on December 31, 2006. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds. For example, the Indiana contract under which we operate can be terminated by the State without cause. Our contracts could also be terminated if we fail to perform in accordance with the standards set by state regulatory agencies. If any of our contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, our business will suffer, and our financial position, results of operations or cash flows may be materially affected.

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

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

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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 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, Texas and Wisconsin 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 financial position, results of operations or cash flows. 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:

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

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

Federal and state governments have enacted fraud and abuse laws and other laws to protect patients' privacy and access to healthcare. In some states, we may be subject to regulation by more than one governmental authority, which may impose overlapping or inconsistent regulations. Violation of these and other laws or regulations governing our operations or the operations of our providers could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide services, the suspension or revocation of our licenses or our exclusion from participating in the Medicaid, SCHIP, Foster Care and ABD 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 of 2002, as well as rules subsequently implemented by the SEC and the New York Stock Exchange, or the NYSE, have imposed various requirements on public companies, including requiring changes in corporate governance practices. Our management and other personnel will continue to devote time to these compliance initiatives.

The Sarbanes-Oxley Act requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal control over financial reporting to allow management to report on the effectiveness of our internal control 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 control over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 causes us to incur substantial expense and management effort. 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.

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For example, in August 2007 CMS issued guidance that imposes requirements on states that cover children in families with incomes above 250% of the federal poverty level. Under these requirements, applicable states must provide assurances to CMS that the state has enrolled at least 95% of the Medicaid and SCHIP eligible children in the state who are in families with incomes below 200% of the federal poverty level in Medicaid or SCHIP and that the number of children insured through private employers has not decreased by more than two percentage points over the prior five year period. Two states in which we have SCHIP contracts, Georgia and New Jersey, are subject to these requirements. If they are unable to meet these requirements, they will be unable to continue to cover children in families with incomes above 250% of the federal poverty level, which would likely decrease our membership in such states. Many states object to these requirements as unduly burdensome and likely to result in a decrease in the number of children covered by SCHIP, and some states, including New Jersey, are pursuing legal challenges against CMS in relation to these requirements. In the guidance, CMS stated that it expected states to comply with the requirements within 12 months of the issuance of the guidance. However, in August 2008, a CMS spokesperson stated that, for the time being, CMS would not take compliance action to enforce this requirement. Further, on February 4, 2009, President Obama issued a memorandum to the Secretary of Health and Human Services requesting the immediate withdrawal of the August 2007 guidance and implementation of SCHIP without the requirements imposed by the August 2007 guidance. We cannot predict whether legal challenges to August 2007 guidance will be successful or whether these requirements will be rescinded by CMS. We cannot predict the impact these requirements will have on our revenue if changes are implemented in states in which we serve SCHIP beneficiaries.

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

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

Changes in federal funding mechanisms may reduce our profitability.

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

On May 29, 2007, CMS issued a final rule that would reduce states' use of intergovernmental transfers for the states' share of Medicaid program funding. By restricting the use of intergovernmental transfers, this rule may restrict some states' funding for Medicaid, which could adversely affect our growth, operations and financial performance. On May 25, 2007, President Bush signed an Iraq war supplemental spending bill that included a one-year moratorium on the effectiveness of the final rule. On June 30, 2008, President Bush signed another Iraq war supplemental spending bill that extends the moratorium on the effectiveness of the final rule until April 1, 2009. We cannot predict whether the rule will ever be implemented and if it is, what impact it will have on our business.

Recent legislative changes in the Medicare program may also affect our business. For example, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 revised cost-sharing requirements for some beneficiaries and requires states to reimburse the federal Medicare program for costs of prescription drug coverage provided to beneficiaries who are enrolled simultaneously in both the Medicaid and Medicare programs. In its fiscal year 2009 budget proposal, the Bush administration has also proposed to further reduce total federal funding for the Medicaid program by $17.4 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 Medicare prescription drug benefit interrupted 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 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 members 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 members 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 financial position, results of operations or cash flows.

Our medical expense includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a

monthly basis as claims receipts and payment information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified.

We can not be sure that our medical claims liability estimates are adequate or that adjustments to those estimates will not unfavorably impact our results of operations. For example, in the three months ended June 30, 2006 we adjusted IBNR by $9.7 million for adverse medical costs development from the first quarter of 2006.

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Additionally, when we commence operations in a new state or region, we have limited information with which to estimate our medical claims liability. For example, we commenced operations in South Carolina in December 2007 and began our Foster Care program in Texas in April 2008. For a period of time after the inception of business in these states, we based our estimates on state provided historical actuarial data and limited actual incurred and received claims. 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. The accuracy of our medical claims liability estimate may also affect our ability to take timely corrective actions, further harming our results.

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

Our premium revenues consist of fixed monthly payments per member and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide healthcare services as established by the state governments. We use a large portion of our revenues to pay the costs of healthcare services delivered to our members. If premiums do not increase when expenses related to medical services rise, our earnings will be affected negatively. In addition, our actual medical services costs may exceed our estimates, which would cause our health benefits ratio, or our expenses related to medical services as a percentage of premium revenue, to increase and our profits to decline. In addition, it is possible for a state to increase the rates payable to the hospitals without granting a corresponding increase in premiums to us. If this were to occur in one or more of the states in which we operate, our profitability would be harmed. In addition, if there is a significant delay in our receipt of premiums to offset previously incurred health benefits costs, our earnings could be negatively impacted.

In some instances, our base premiums are subject to an adjustment, or risk score, based on the acuity of our membership. Generally, the risk score is determined by the State analyzing encounter submissions of processed claims data to determine the acuity of our membership relative to the entire state's Medicaid membership. The risk score is dependent on several factors including our providers' completeness and quality of claims submission, our processing of the claim, submission of the processed claims in the form of encounters to the states' encounter systems and the states' acceptance and analysis of the encounter data. If the risk scores assigned to our premiums that are risk adjusted are not adequate or do not appropriately reflect the acuity of our membership, our earnings will be affected negatively.

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.

Our investment portfolio may suffer losses from reductions in market interest rates and changes in market conditions which could materially and adversely affect our results of operations or liquidity.

As of December 31, 2008, we had $480.4 million in cash, cash equivalents and short-term investments and $341.7 million of long-term investments and restricted deposits. We maintain an investment portfolio of cash equivalents and short-term and long-term investments in a variety of securities which may include commercial paper, certificates of

deposit, money market funds, municipal bonds, corporate bonds, instruments of the U.S. Treasury, insurance contracts and equity securities. These investments are subject to general credit, liquidity, market and interest rate risks. Substantially all of these securities are subject to interest rate and credit risk and will decline in value if interest rates increase or one of the issuers' credit ratings is reduced. As a result, we may experience a reduction in value or loss of liquidity of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition. For example, in the third quarter of 2008, we recorded a loss on investments of approximately $4.5 million due to a loss in a money market fund.

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 provide any assurance 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.

Acquisitions of unfamiliar new businesses could negatively impact our business.

We are subject to the expenditures and risks associated with entering into any new line of business. Our failure to properly manage these expenditures and risks could have a negative impact on our overall business. For example, effective July 2008, we completed the previously announced acquisition of Celtic Group, Inc., the parent company of Celtic Insurance Company, or Celtic. Celtic is a national individual health insurance provider that provides health insurance to individual customers and their families. While we believe that the addition of Celtic will be complementary to our business, we have not previously operated in the individual health care industry.

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

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

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

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

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

Operations in a few states have accounted for most of our premium revenues to date. If we were unable to continue to operate in any of our current states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. 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. 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 provide any assurance 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 non-cancelable agreements due to alleged actions or inactions by us. Even if these allegations represent attempts to avoid or renegotiate contractual terms that have become economically disadvantageous to the providers, it is possible that in the future a provider may pursue such a claim successfully. In addition, we are aware that other managed care organizations have been subject to class action suits by physicians with respect to claim payment procedures, and we may be subject to similar claims. Regardless of whether any claims brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively.

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

We may be unable to attract and retain key personnel.

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our business. If we lose one or more members of our senior management team, including our chief executive officer, Michael F. Neidorff, who has been instrumental in developing our business strategy and forging our business relationships, our business and financial position, results of operations or cash flows 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 financial position, results of operations or cash flows.

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 financial position, results of operations or cash flows.

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

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

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

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

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Growth in the number of Medicaid-eligible persons during economic downturns could cause our financial position, results of operations or cash flows 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 financial position, results of operations or cash flows 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 financial position, results of operations or cash flows 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 provide any assurance 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 financial position, results of operations or cash flows. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and time consuming and require significant attention from our management. For example, we have in the past, or may be subject to in the future, securities class action lawsuits, IRS examinations or similar regulatory actions. Any such matters could harm our business and financial position, results of operations or cash flows.

If we are unable to complete the previously announced sale of certain of assets of our New Jersey health plan in a timely manner, our business could suffer.

On November 20, 2008, we announced that we had entered into an agreement with AMERIGROUP Corporation, or AMERIGROUP, to sell certain assets of our subsidiary University Health Plan, Inc. in the State of New Jersey to AMERIGROUP. The agreement contains a number of conditions to closing, including (i) the approval of regulators in New Jersey, (ii) the lack of a material adverse effect, and (iii) other customary conditions. On December 31, 2008, we announced that we had received a termination notice from AMERIGROUP relating to the New Jersey transaction. As we have previously stated, we do not believe that there is cause to terminate the New Jersey agreement and are prepared to pursue all available means to bring this transaction to closure. To this end, on January 8, 2009, we announced that, in response to AMERIGROUP's purported termination of this agreement, we had filed a lawsuit against AMERIGROUP in the Superior Court of New Jersey Chancery Division. Nonetheless, if we are unable to close the New Jersey transaction in a timely manner, our results of operations could be negatively impacted.

Risks related to our corporate headquarters' project could harm our financial position, results of operations or cash flows.

In 2008, our capital expenditures included $27.0 million for land and fees associated with the construction of a real estate development on the property adjoining our corporate office, which we believe is necessary to accommodate our growing business. We are currently negotiating our involvement as a joint venture partner in an entity that will develop the properties. Due to the global financial crisis and disruptions in the capital and credit markets, we may be unable to complete this project under economically feasible terms. If the Company is unable to complete the development or if the Company delays or abandons the real estate project, it may have an adverse impact on our financial position, results of operations or cash flows. For example, in 2007 we abandoned a previously planned redevelopment project and recorded a pre-tax impairment charge of $7.2 million. Our operations and efficiency could also be impacted if the development is not completed as there is limited office space for us to expand in the market near our existing headquarters as our business continues to grow.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

We own our corporate office headquarters building located in St. Louis, Missouri. During 2008, our capital expenditures included land and fees for the construction of a new real estate development on the property adjoining our corporate office, which we believe is necessary to accommodate our growing business. We are currently negotiating our involvement as a joint venture partner in the entity that will develop the relevant properties.

We generally lease space in the states where our health plans, specialty companies and claims processing facilities operate. We are required by various insurance and regulatory authorities to have offices in the service areas where we provide benefits. We believe our current facilities are adequate to meet our operational needs for the foreseeable future.

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Item 3. Legal Proceedings

On January 8, 2009, we filed a complaint in the Chancery Division of the Superior Court of New Jersey, asserting a breach of contract claim against AMERIGROUP New Jersey, or AGPNJ, and a tortuous interference with contract claim against AMERIGROUP Corporation, in connection with AGPNJ's refusal to proceed to closing under its contract to purchase certain assets of University Health Plan's or, UHP's, business. In December 2008, AGPNJ sent us a termination notice claiming that a material adverse effect had occurred under the contract and attempted to terminate the contract. We are contesting whether a material adverse effect occurred and correspondingly the propriety and validity of the purported termination, and are seeking to obtain specific performance of the contract and damages.

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

Item 4. Submission of Matters to a Vote of Security Holders

None.

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PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market for Common Stock; Dividends

Our common stock has been traded and quoted on the New York Stock Exchange under the symbol "CNC" since October 16, 2003.

	2008 Stock Price		2007 Stock Price	
	High	Low	High	Low
First Quarter	$ 28.49	$ 13.58	$ 26.66	$ 20.68
Second Quarter	21.70	13.10	24.28	19.35
Third Quarter	24.67	16.40	23.79	17.65
Fourth Quarter	21.61	15.23	27.73	21.26

As of February 6, 2009, there were 49 holders of record of our common stock.

We have never declared any cash dividends on our capital stock and currently anticipate that we will retain any future earnings for the development, operation and expansion of our business.

Issuer Purchases of Equity Securities

In October 2008, our board of directors extended the previously adopted November 2005 stock repurchase program, authorizing us to repurchase up to four million shares of common stock from time to time on the open market or through privately negotiated transactions. The repurchase program expires October 31, 2009, but we reserve the right to suspend or discontinue the program at any time. We have established a trading plan with a registered broker to repurchase shares under certain market conditions. During the year ended December 31, 2008, we repurchased 1,218,858 shares at an average price of $19.29 and an aggregate cost of $23.5 million. During the quarter ended December 31, 2008, with the exception of the 11,346 shares footnoted below, we did not repurchase any shares other than through this publicly announced program.

Issuer Purchases of Equity Securities
Fourth Quarter 2008

Period	Total Number of Shares Purchased	Average Price Per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs

October 1 – October 31, 2008	264,3071	$	18.94	264,008	1,934,481
November 1 – November 30, 2008	2,5972		17.12	—	1,934,481
December 1 – December 31, 2008	8,4502		16.07	—	1,934,481
TOTAL	275,354	$	18.83	264,008	1,934,481

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1 299 shares acquired in October 2008 represent shares relinquished to the Company by certain employees for payment of taxes upon vesting of restricted stock units.
2 Shares acquired in November and December 2008 represent shares relinquished to the Company by certain employees for payment of taxes upon vesting of restricted stock units.

Stock Performance Graphs

The graph below compares the cumulative total stockholder return on our common stock for the period from December 31, 2003 to December 31, 2008 with the cumulative total return of the New York Stock Exchange Composite Index and the Morgan Stanley Health Care Payor Index over the same period. The graph assumes an investment of $100 on December 31, 2003 in our common stock (at the last reported sale price on such day), the New York Stock Exchange Composite Index and the Morgan Stanley Health Care Payor Index and assumes the reinvestment of any dividends.

	12/31/2003	12/31/2004	12/31/2005	12/31/2006	12/31/2007	12/31/2008
Centene Corporation	$ 100.00	$ 202.36	$ 187.65	$ 175.37	$ 195.86	$ 140.69
New York Stock Exchange Composite Index	$ 100.00	$ 112.16	$ 119.96	$ 141.38	$ 150.69	$ 89.06
MS Health Care Payor Index	$ 100.00	$ 146.27	$ 200.56	$ 213.90	$ 248.53	$ 112.32

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Item 6. Selected Financial Data

The following selected consolidated financial data should be read in conjunction with the consolidated financial statements and related notes and "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" included in our Annual Report on Form 10-K. The assets, liabilities and results of operations of FirstGuard and University Health Plans have been classified as discontinued operations for all periods presented. The data for the years ended December 31, 2008, 2007 and 2006 and as of December 31, 2008 and 2007 are derived from consolidated financial statements included elsewhere in this filing. The data for the years ended December 31, 2005 and 2004 and as of December 31, 2006, 2005 and 2004 are derived from consolidated financial statements not included in this filing.

	Year Ended December 31,				
	2008	2007	2006	2005	2004
	(In thousands, except share data)				
Consolidated Statements of Operations:					
Revenues:					
Premium	$ 3,199,360	$ 2,611,953	$ 1,707,439	$ 1,095,308	$ 851,794
Premium tax	90,202	76,567	35,848	6,079	4,911
Service	74,953	80,508	79,159	13,456	8,532
Total revenues	3,364,515	2,769,028	1,822,446	1,114,843	865,237
Expenses:					
Medical costs	2,640,335	2,190,898	1,436,371	897,077	692,348
Cost of services	56,920	61,348	60,287	5,608	7,771
General and administrative expenses	444,733	384,970	267,712	162,432	111,924
Premium tax expense	90,966	76,567	35,848	6,079	4,911
Total operating expenses	3,232,954	2,713,783	1,800,218	1,071,196	816,954
Earnings from operations	131,561	55,245	22,228	43,647	48,283
Other income (expense):					
Investment and other income	21,728	24,452	15,511	8,417	6,066
Interest expense	(16,673)	(15,626)	(10,574)	(3,985)	(680)
Earnings from continuing operations before income taxes	136,616	64,071	27,165	48,079	53,669
Income tax expense	52,435	23,031	9,565	17,242	19,835
Net earnings from continuing operations	84,181	41,040	17,600	30,837	33,834
Discontinued operations, net of income tax (benefit) expense of $(281), $(31,563), $12,412, $12,982, and $6,140, respectively	(684)	32,362	(61,229)	24,795	10,478
Net earnings (loss)	$ 83,497	$ 73,402	$ (43,629)	$ 55,632	$ 44,312
Net earnings (loss) per common share:					
Basic:					
Continuing operations	$ 1.95	$ 0.95	$ 0.41	$ 0.73	$ 0.83
Discontinued operations	(0.02)	0.74	(1.42)	0.58	0.26
Basic earnings (loss) per common share	$ 1.93	$ 1.69	$ (1.01)	$ 1.31	$ 1.09
Diluted:					
Continuing operations	$ 1.90	$ 0.92	$ 0.39	$ 0.69	$ 0.78
Discontinued operations	(0.02)	0.72	(1.37)	0.55	0.24
Diluted earnings (loss) per common share	$ 1.88	$ 1.64	$ (0.98)	$ 1.24	$ 1.02

Weighted average number of common shares outstanding:					
Basic	43,275,187	43,539,950	43,160,860	42,312,522	40,820,909
Diluted	44,398,955	44,823,082	44,613,622	45,027,633	43,616,445

	2008	2007	December 31, 2006	2005	2004
			(In thousands)		
Consolidated Balance Sheet Data:					
Cash and cash equivalents	$ 370,999	$ 267,305	$ 237,514	$ 112,269	$ 55,850
Investments and restricted deposits	451,058	369,545	174,431	163,489	186,777
Total assets	1,451,152	1,121,824	894,980	668,030	527,934
Medical claims liability	373,037	313,364	232,496	123,102	121,790
Long-term debt	264,637	206,406	174,646	92,448	46,973
Total stockholders' equity	501,272	415,047	326,423	352,048	271,312

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Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

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

OVERVIEW

We are a multi-line healthcare enterprise operating in two segments. Our Medicaid Managed Care segment provides Medicaid and Medicaid-related programs to organizations and individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program, or SCHIP, and, Supplemental Security Income including Aged, Blind or Disabled programs, or ABD. Our Specialty Services segment provides specialty services, including behavioral health, individual health insurance, life and health management, long-term care programs, managed vision, nurse triage, and pharmacy benefits management, to state programs, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries. Our Specialty Services segment also provides a full range of healthcare solutions for the rising number of uninsured Americans.

During 2008, we announced our intention to sell certain assets of University Health Plans, Inc, or UHP, our New Jersey health plan. In addition, our Medicaid contract in Kansas terminated effective December 31, 2006, and we sold the operating assets of FirstGuard Health Plan, Inc., our Missouri health plan, effective February 1, 2007. Unless specifically noted, the discussions below are in the context of continuing operations, and therefore, exclude our New Jersey health plan, UHP, as well as our Kansas and Missouri health plans, collectively referred to as FirstGuard. The results of operations for UHP and FirstGuard are classified as discontinued operations for all periods presented.

Our financial performance for 2008 is summarized as follows:

— Year-end Medicaid Managed Care membership of 1,184,800.
— Revenues of $3.4 billion.
— Health Benefits Ratio, or HBR, of 82.5%.
— General and Administrative, or G&A, expense ratio of 13.6%.
— Diluted net earnings per share of $1.90.
— Total operating cash flows of $222.0 million.

The following new contracts and acquisitions contributed to our growth over the last two years:

— In October 2008, we began operating under our contract in Arizona to provide Acute Care services in Yavapai county, with 14,900 members at December 31, 2008.
— Effective July 1, 2008, we completed the previously announced acquisition of Celtic, a health insurance carrier focused on the individual health insurance market.
— In April 2008, we began operating under our new contract in Texas to provide statewide managed care services to participants in the Texas Foster Care program, with 33,100 members at December 31, 2008.
— In 2007, we acquired PhyTrust of South Carolina, LLC, as well as Physician's Choice, LLC, both of which managed care on a non-risk basis for Medicaid members in South Carolina. We became licensed in 2007 to provide risk-based managed care in the State and participated in the transition of the State's conversion to at-risk managed care. We served 31,300 at-risk members in South Carolina at December 31, 2008.
— In July 2007, we acquired a 49% ownership interest in Access Health Solutions, LLC, or Access, which provides managed care for Medicaid recipients in Florida, with 97,100 members at December 31, 2008.
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In February 2007, we began managing care for ABD recipients in the San Antonio and Corpus Christi markets of Texas with 34,600 members at December 31, 2008.

— In 2007, we began managing care for ABD members in Ohio, with 13,900 members at December 31, 2008.

We have opportunities to continue our growth through the following:

— In November 2008, we announced the planned acquisition of certain assets of AMERIGROUP Community Care of South Carolina. We expect this acquisition to close during the first quarter of 2009.

— In February 2009, we began converting membership in Florida from Access, on a non-risk basis to our new subsidiary, Sunshine State Health Plan on an at-risk basis.

RESULTS OF CONTINUING OPERATIONS AND KEY METRICS

The following discussion and analysis is based on our consolidated statements of operations, which reflect our results of operations for the years ended December 31, 2008, 2007 and 2006, as prepared in accordance with generally accepted accounting principles in the United States, or GAAP.

Summarized comparative financial data for 2008, 2007 and 2006 are as follows ($ in millions):

	2008	2007	2006	% Change 2007-2008	% Change 2006-2007
Premium	$ 3,199.3	$ 2,611.9	$ 1,707.4	22.5%	53.0%
Premium tax	90.2	76.6	35.8	17.8%	113.6%
Service	75.0	80.5	79.2	(6.9) %	1.7%
Total revenues	3,364.5	2,769.0	1,822.4	21.5%	51.9%
Medical costs	2,640.3	2,190.9	1,436.4	20.5%	52.5%
Cost of services	56.9	61.3	60.3	(7.2)%	1.8%
General and administrative expenses	444.7	385.0	267.7	15.5%	43.8%
Premium tax expense	91.0	76.6	35.8	18.8%	113.6%
Earnings from operations	131.6	55.2	22.2	138.1%	148.5%
Investment and other income, net	5.0	8.8	5.0	(42.7)%	78.8%
Earnings before income taxes	136.6	64.0	27.2	113.2%	135.9%
Income tax expense	52.4	23.0	9.6	127.7%	140.8%
Net earnings from continuing operations	84.2	41.0	17.6	105.1%	132.2%
Discontinued operations, net of income tax (benefit) expense of $(0.3), $(31.6) and $12.4 respectively	(0.7)	32.4	(61.2)	(102.1)%	(152.9)%
Net earnings (loss)	$ 83.5	$ 73.4	$ (43.6)	13.8%	(268.2)%
Diluted earnings (loss) per common share:					
Continuing operations	$ 1.90	$ 0.92	$ 0.39	106.5%	135.9%
Discontinued operations	(0.02)	0.72	(1.37)	(102.8)%	(152.6)%
Total diluted earnings (loss) per common share	$ 1.88	$ 1.64	$ (0.98)	14.6%	(267.3)%

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Revenues and Revenue Recognition

Our Medicaid Managed Care segment generates revenues primarily from premiums we receive from the states in which we operate health plans. We receive a fixed premium per member per month pursuant to our state contracts. We generally receive premium payments during the month we provide services and recognize premium revenue during the period in which we are obligated to provide services to our members. In some instances, our base premiums are subject to an adjustment, or risk score, based on the acuity of our membership. Generally, the risk score is determined by the State analyzing encounter submissions of processed claims data to determine the acuity of our membership relative to the entire state's Medicaid membership. Some states enact premium taxes or similar assessments, collectively, premium taxes, and these taxes are recorded as a component of revenues as well as operating expenses. Some contracts allow for additional premium associated with certain supplemental services provided such as maternity deliveries. Revenues are recorded based on membership and eligibility data provided by the states, which may be adjusted by the states for updates to this data. These eligibility adjustments have been immaterial in relation to total revenue recorded and are reflected in the period known.

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

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

Our total revenue increased in the year ended December 31, 2008 over the previous year primarily through 1) membership growth in the Medicaid Managed Care segment, 2) premium rate increases, and 3) growth in our Specialty Services segment.

1. Membership growth

From December 31, 2006 to December 31, 2008, we increased our Medicaid Managed Care membership by 11.3%. The following table sets forth our membership by state in our Medicaid Managed Care segment:

	December 31,		
	2008	2007	2006
Georgia	288,300	287,900	308,800
Indiana	175,300	154,600	183,100
Ohio	133,400	128,700	109,200
South Carolina	31,300	31,800	—
Texas	431,700	354,400	298,500
Wisconsin	124,800	131,900	164,800
Total	1,184,800	1,089,300	1,064,400

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

	December 31,		
	2008	2007	2006
Medicaid	862,500	807,600	843,700
SCHIP/Foster Care	257,300	214,600	205,800
ABD/Medicare	65,000	67,100	14,900
Total	1,184,800	1,089,300	1,064,400

From December 31, 2007 to December 31, 2008 our membership increased as a result of growth in Indiana and Texas. In Texas, we increased our membership through organic growth of SCHIP, especially in the Exclusive Provider Organization, or EPO, market. In addition, we increased Texas membership through our new Foster Care program, with 33,100 members at December 31, 2008. We increased our membership in Indiana through temporary eligibility determinations and network expansions. Our membership decreased in Wisconsin due to the termination of certain provider contracts. In South Carolina, we continue to add at-risk membership as additional counties convert, with 31,300 at-risk members at December 31, 2008. Substantially all of the prior year membership in South Carolina was on a non-risk basis. In Florida, Access served 97,100 members on a non-risk basis at December 31, 2008.

From December 31, 2006 to December 31, 2007, our membership increased primarily as a result of increases in Ohio, South Carolina and Texas. We increased our Medicaid membership in Ohio by adding members under our new contract in the Northwest region. We also increased our membership in Ohio with the commencement of our new contract to serve Aged, Blind or Disabled members. Our membership in South Carolina was primarily on a non-risk basis; we began conversion to at-risk in December 2007, with 100 at-risk members at December 31, 2007. In Texas, we increased our membership through new Medicaid, SCHIP and ABD contracts in the Corpus Christi, San Antonio, Austin, and Lubbock markets. Our membership decreased in Wisconsin because of more stringent state eligibility requirements for the Medicaid and SCHIP programs, eligibility administration issues and the termination of certain physician contracts associated with a high cost hospital system. Our membership decreased in Indiana primarily due to adjustments made to our provider network made in connection with our new state-wide contract as well as the termination of certain non-exclusive physician contracts. In Florida, Access served 90,600 members on a non-risk basis at December 31, 2007.

The total revenue associated with University Health Plans included in results from discontinued operations was $150.6 million, $150.3 million, and $139.5 million in 2008, 2007 and 2006, respectively. Our University Health Plan membership was 55,200, 57,300 and 58,900 at December 31, 2008, 2007 and 2006, respectively. The total revenue associated with FirstGuard included in results from discontinued operations was $0, $6.7 million, and $317.0 million in 2008, 2007 and 2006, respectively. Our FirstGuard membership was 138,900 at December 31, 2006.

2. Premium rate increases

In 2008, we received premium rate increases in some markets which yield a 2.7% composite increase across all of our markets. In 2007, we received premium rate increases in some markets which yield a 2.6% composite increase across all of our markets.

In November 2007, we received a contract amendment from the State of Georgia providing for an effective premium rate increase in Georgia of approximately 3.8% effective July 1, 2007. The state also mandated service changes, retroactively recalculated certain rate cells and adjusted for duplicate member issues. We executed this amendment on November 16, 2007. The State of Georgia returned the fully executed contract in January 2008 and, accordingly, we recorded the additional revenue, retroactive to July 1, 2007, in the first quarter of 2008. This premium revenue, related to the period from July 1, 2007 to December 31, 2007, totals approximately $20.8 million. Approximately $7.3 million of this amount is related to the mandated services, rate cell changes and duplicate member issues, the remaining $13.5 million yields the calculated 3.8% increase.

3. Specialty Services segment growth

For the year ended December 31, 2008, Specialty Services segment revenue from external customers was $344.3 million compared to $245.4 million for the same prior year period. The increase is primarily attributable to the acquisition of Celtic as well as increasing membership for both our behavioral health company, Cenpatico, and Bridgeway.

The following table sets forth our membership by line of business in our Specialty Services segment:

	December 31,		
	2008	2007	2006
Cenpatico Behavioral Health:			
Kansas	41,100	39,000	36,600
Arizona	105,000	99,900	94,500
Bridgeway:			
Long-term Care	2,100	1,600	900
Acute Care	14,900	—	—

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Operating Expenses

Medical Costs

Our medical costs include payments to physicians, hospitals, and other providers for healthcare and specialty services claims. Medical costs also include estimates of medical expenses incurred but not yet reported, or IBNR, and estimates of the cost to process unpaid claims. We use our judgment to determine the assumptions to be used in the calculation of the required IBNR estimate. The assumptions we consider include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims.

Our development of the IBNR estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified.

Additionally, we contract with independent actuaries to review our estimates on a quarterly basis. The independent actuaries provide us with a review letter that includes the results of their analysis of our medical claims liability. We do not solely rely on their report to adjust our claims liability. We utilize their calculation of our claims liability only as additional information, together with management's judgment to determine the assumptions to be used in the calculation of our liability for medical costs.

While we believe our IBNR estimate is appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. Accordingly, we can not assure you that healthcare claim costs will not materially differ from our estimates.

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

	Year Ended December 31,		
	2008	2007	2006
Medicaid and SCHIP	80.6%	82.8%	84.0%
ABD and Medicare	91.1	91.4	88.8
Specialty Services	83.8	78.4	83.9
Total	82.5	83.9	84.1

Our consolidated HBR for the year ended December 31, 2008 was 82.5%, a decrease of 1.4% over 2007. The decrease for the year ended December 31, 2008 over 2007 is due to the effect of recording the Georgia premium rate increase retroactive to July 1, 2007 in 2008. Our consolidated HBR for the year ended December 31, 2007 was 83.9%, a decrease of 0.2% over 2006. The decrease is primarily attributable to increased premium yield combined with a moderating medical cost trend particularly with a decrease in pharmacy costs, offset by the new

ABD business in Ohio and the transition of these new members into a managed care environment.

Cost of Services

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

General and Administrative Expenses

Our general and administrative expenses, or G&A, primarily reflect wages and benefits, including stock compensation expense, and other administrative costs associated with our health plans, specialty companies and centralized functions that support all of our business units. Our major centralized functions are finance, information systems and claims processing. G&A increased in both the years ended December 31, 2008 and December 31, 2007 primarily due to expenses for additional facilities and staff to support our growth. G&A also increased in 2008 as a result of the acquisition of Celtic. G&A in 2007 also included charges totaling $12.4 million for fixed asset impairment, severance for an organizational realignment, and a contribution to our charitable foundation with a portion of the proceeds from the sale of FirstGuard Missouri. The fixed asset impairment resulted from abandoning a previously planned headquarters development in Clayton, Missouri.

Our G&A expense ratio represents G&A expenses as a percentage of the sum of Premium revenues and Service revenues, and reflects the relationship between revenues earned and the costs necessary to earn those revenues. The consolidated G&A expense ratio for the years ended December 31, 2008, 2007 and 2006 were 13.6%, 14.3% and 15.0%, respectively. The decrease in the ratio in 2008 primarily reflects the overall leveraging of our expenses over higher revenues, partially offset by the effect of the acquisition of Celtic and of our start-up costs in Florida and for our Texas Foster Care product. The decrease in the ratio in 2007 primarily reflects the overall leveraging of our expenses over higher revenues offset by the effect of our start-up costs in South Carolina and for our Texas Foster Care product, and the $12.4 million charge discussed above.

Other Income (Expense)

The following table summarizes the components of investment and other income, net:

	Year Ended December 31,		
	2008	2007	2006
Investment income	$ 15.3	$ 23.9	$ 15.5
Earnings from equity method investee	6.4	0.5	—
Interest expense	(16.7)	(15.6)	(10.5)
Investment and other income, net	$ 5.0	$ 8.8	$ 5.0

Other income (expense) consists principally of investment income from our cash and investments, our equity in earnings of investments, and interest expense on our debt. Investment income decreased $8.6 million in 2008, over the comparable periods in 2007. The decrease in 2008 was due to a loss on investments of $4.5 million recorded in the third quarter of 2008 and an overall decline in market interest rates. The loss was primarily related to investments in the Reserve Primary money market fund whose Net Asset Value fell below $1.00 per share. The loss represents less

than 1% of Centene's cash and investment portfolio as of December 31, 2008. We expect to recover 95% of our Reserve Primary Fund investments. Money market funds are generally recorded in Cash and cash equivalents in our balance sheet, however, our investment in the Reserve Primary money market fund is recorded in Short-term investments due to the restrictions placed on redemptions imposed by the fund. As of December 31, 2008 we had recovered most of the investment in the Reserve Primary Fund. These decreases were partially offset by an increase in earnings from our equity method investee, Access. Investment income increased $8.4 million in 2007, over the comparable period in 2006. The increase was primarily a result of larger investment balances. Interest expense increased in 2007, over the comparable period in 2006 due to larger debt balances resulting from our senior notes issuance.

Income Tax Expense

Our effective tax rate in 2008 was 38.4% compared to 35.9% in 2007. The increase in the current year was due to higher state taxes as a result of a change in the estimated benefit to be realized from New Jersey State net operating loss carryforwards. Our 2007 effective tax rate was 35.9% compared to 35.2% for the corresponding period in 2006. The decrease was primarily due to the effect of an increase in tax-exempt investment income and lower state taxes.

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Discontinued Operations

In November 2008, we announced our intention to sell certain assets of University Health Plans, Inc, or UHP, our New Jersey health plan. Accordingly, the results of operations for UHP are reported as discontinued operations for all periods presented. UHP was previously reported in the Medicaid Managed Care segment. In November 2008, we announced a definitive agreement to sell certain assets of our New Jersey health plan to AMERIGROUP New Jersey, or AGPNJ. In December 2008, AGPNJ sent us a termination notice. We have filed a complaint seeking specific performance of the contract and damages. Additional information regarding this matter is included in "Item 3. Legal Proceedings" included elsewhere in this Annual Report on Form 10-K.

In August 2006, FirstGuard Health Plan Kansas, Inc., or FirstGuard Kansas, our wholly owned subsidiary, received notification from the Kansas Health Policy Authority that its Medicaid contract scheduled to terminate December 31, 2006 would not be renewed. In 2006, we also evaluated our strategic alternatives for our FirstGuard Missouri health plan and decided to divest the business. The sale of the operating assets of FirstGuard Missouri was completed effective February 1, 2007. Accordingly, the results of operations for FirstGuard Kansas and FirstGuard Missouri are reported as discontinued operations for all periods presented. FirstGuard Kansas and FirstGuard Missouri were previously reported in the Medicaid Managed Care segment. Additionally, the assets and liabilities of the discontinued businesses are segregated in the consolidated balance sheet.

Net earnings (losses) from discontinued operations were a net loss of $0.7 million in 2008 compared to earnings of $32.4 million in 2007 and a net loss of $61.2 million in 2006. The 2008 results include a one-time charge of $3.7 million primarily for asset impairments and employee severance related to the sale of the New Jersey health plan. At December 31, 2008, the remaining liability for these charges was $1.1 million. In 2007, we abandoned the stock of our FirstGuard health plans resulting in tax benefits of $32.6 million, net of the associated asset write-offs. The 2007 results also included a gain on the sale of FirstGuard Missouri of $7.5 million, as well as operational and exit costs associated with FirstGuard. The 2006 results included a FirstGuard goodwill impairment charge of $81.1 million, a FirstGuard intangible asset impairment charge of $6.0 million, as well as operational and exit costs associated with FirstGuard.

LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows for the years ended December 31, 2008, 2007 and 2006, that we use throughout our discussion of liquidity and capital resources (in millions).

	Year Ended December 31,		
	2008	2007	2006
Net cash provided by operating activities	$ 222.0	$ 202.2	$ 195.0
Net cash used in investing activities	(153.9)	(225.5)	(150.2)
Net cash provided by financing activities	42.4	20.8	78.9
Net increase (decrease) in cash and cash equivalents	$ 110.5	$ (2.5)	$ 123.7

We finance our activities primarily through operating cash flows and borrowings under our revolving credit facility. Our total operating activities provided cash of $222.0 million in 2008, $202.2 million in 2007 and $195.0 million in 2006. Cash flow from operations in 2008 reflected an increase in our Medical claims liability as a result of

new business in Texas, South Carolina and Arizona. Cash flow from operations also increased by a change in our cash management procedure whereby negative book cash balances resulting from checks issued but not yet presented to our bank for payment are now included in Accounts payable and accrued expenses. These factors were partially offset by a decrease in unearned revenue resulting from a timing difference with the receipt of our December revenue for our Ohio health plan. The Medical claims liability increased in 2007 reflecting new business in Ohio and Texas, offset by the payment in 2007 of FirstGuard claims incurred in 2006.

Our investing activities used cash of $153.9 million in 2008, $225.5 million in 2007 and $150.2 million in 2006. Cash flows from investing activities in 2008 included the purchase price of Celtic which we acquired on July 1, 2008, capital expenditures and our investment in the Reserve Primary fund previously discussed. At December 31, 2008, our investment in the Reserve Fund totaled $13.0 million and was included in Short-term investments. Our investing activities in 2007 consisted primarily of additions to the investment portfolios of our regulated subsidiaries including transfers from cash and cash equivalents to long-term investments. Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets within our guidelines. Net cash provided by and used in investing activities will fluctuate from year to year due to the timing of investment purchases, sales and maturities. As of December 31, 2008, our investment portfolio consisted primarily of fixed-income securities with an average duration of 2.4 years. Cash is invested in investment vehicles such as municipal bonds, corporate bonds, instruments of the U.S. Treasury, insurance contracts, commercial paper and equity securities. These securities generally are actively traded in secondary markets and the reported fair market value is determined based on recent trading activity and other observable inputs. The states in which we operate prescribe the types of instruments in which our regulated subsidiaries may invest their cash.

We spent $65.2 million, $53.9 million and $50.3 million in 2008, 2007 and 2006, respectively, on capital assets consisting primarily of software and hardware upgrades, and furniture, equipment and leasehold improvements associated with office and market expansions. The expenditures in 2008 included $32.0 million for computer hardware and software. We anticipate spending approximately $30 million on capital expenditures in 2009, primarily associated with system enhancements and market expansions.

In 2008, our capital expenditures included $27.0 million for land and fees associated with the construction of a real estate development on the property adjoining our corporate office, which we believe is necessary to accommodate our growing business. We are currently negotiating our involvement as a joint venture partner in an entity that will develop the properties. If the Company is unable to complete the development or if the Company delays or abandons the real estate project, it may have an adverse impact on our financial position, results of operations or cash flows. Our operations and efficiency could also be impacted if the development is not completed as there is limited office space for us to expand in the market near our existing headquarters as our business continues to grow.

Our financing activities provided cash of $42.4 million in 2008, $20.8 million in 2007 and $78.9 million in 2006. During 2008, our financing activities primarily related to proceeds from borrowings under our $300 million credit facility and stock repurchases. During 2007, our financing activities primarily related to proceeds from issuance of $175 million in senior notes as discussed below.

At December 31, 2008, we had working capital, defined as current assets less current liabilities, of $25.4 million, as compared to $(40.5) million at December 31, 2007. We manage our short-term and long-term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short-term requirements as needed. Our working capital was negative at December 31, 2007 due to our efforts to increase investment returns through purchases of investments that have maturities of greater than one year and, therefore, are classified as long-term.

Cash, cash equivalents and short-term investments were $480.4 million at December 31, 2008 and $313.4 million at December 31, 2007. Long-term investments were $341.7 million at December 31, 2008 and $323.5 million at December 31, 2007, including restricted deposits of $9.3 million and $6.4 million, respectively. At December 31,

2008, cash and investments held by our unregulated entities totaled $24.1 million while cash and investments held by our regulated entities totaled $798.0 million. Additionally, we held regulated cash and investments of $30.1 million from discontinued operations. Upon completion of the sale of assets of UHP and the subsequent payment of medical claims liabilites and other liabilities at the closing date, the remaining regulated cash of UHP will be transferred to our unregulated cash.

We have a $300 million revolving credit agreement. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. There is a commitment fee on the unused portion of the agreement that ranges from 0.15% to 0.275% depending on the total debt to EBITDA ratio. The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt to EBITDA ratios and minimum net worth. The agreement will expire in September 2011. As of December 31, 2008, we had $63.0 million in borrowings outstanding under the agreement and $24.1 million in letters of credit outstanding, leaving availability of $212.9 million. As of December 31, 2008, we were in compliance with all covenants.

In 2007, we issued $175 million aggregate principal amount of our 7 ¼% Senior Notes due April 1, 2014, or the Notes. The Notes were registered under the Securities Act of 1933, pursuant to a registration rights agreement with the initial purchasers. The indenture governing the Notes contains non-financial and financial covenants, including requiring a minimum fixed charge coverage ratio. Interest is paid semi-annually in April and October. As of December 31, 2008, we were in compliance with all covenants.

We have a stock repurchase program authorizing us to repurchase up to four million shares of common stock from time to time on the open market or through privately negotiated transactions. In October 2008, the repurchase program was extended through October 31, 2009, but we reserve the right to suspend or discontinue the program at any time. During the year ended December 31, 2008, we repurchased 1,218,858 shares at an average price of $19.29. We have established a trading plan with a registered broker to repurchase shares under certain market conditions.

On July 1, 2008 we completed the acquisition of Celtic for a purchase price of approximately $82.0 million, net of unregulated cash acquired. Concurrent with the acquisition, we received regulatory approval to pay a dividend from Celtic to Centene in an amount of $31.4 million, while still maintaining a capital structure we believe to be conservative. As a result of the dividend, the net effect on our unregulated cash was approximately $50 million. During the year ended December 31, 2008, we received additional dividends of $17.0 million from other regulated subsidiaries.

Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our credit facility will be sufficient to finance our planned acquisition of AMERIGROUP Community Care of South Carolina, our general operations and capital expenditures for at least 12 months from the date of this filing.

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Our contractual obligations at December 31, 2008 consisted of medical claims liability, debt, operating leases, purchase obligations, interest on long-term debt, unrecognized tax benefits and other long-term liabilities. Our debt consists of borrowings from our credit facilities, mortgages and capital leases. The purchase obligations consist primarily of software purchase and maintenance contracts. The contractual obligations and estimated period of payment over the next five years and beyond are as follows (in thousands):

	Payments Due by Period				
	Total	Less Than 1 Year	1-3 Years	3-5 Years	More Than 5 Years
Medical claims liability	$ 373,037	$ 373,037	$ —	$ —	$ —
Debt 1	264,892	255	83,861	534	180,242
Operating lease obligations	121,795	20,490	32,563	20,248	48,494
Purchase obligations	38,474	19,426	13,878	3,546	1,624
Interest on long-term debt 2	69,781	12,687	25,375	25,375	6,344
Unrecognized tax benefits 3	4,054	—	3,982	72	—
Other long-term liabilities 4	39,337	—	10,884	8,594	19,859
Total	$ 911,370	$ 425,895	$ 170,543	$ 58,369	$ 256,563

1 Includes debt related to capital lease obligations.
2 Interest on $175,000 Senior Notes.
3 Unrecognized tax benefits relate to the provision for FASB Interpretation No. 48.
4 Includes $15,949 separate account liabilities from third party reinsurance that will not be settled in cash.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

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

Our subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of December 31, 2008, our subsidiaries, including UHP, had aggregate statutory capital and surplus of $391.4 million, compared with the required minimum aggregate statutory capital and surplus requirements of $241.5 million and we estimate our Risk Based Capital, or RBC, percentage to be 340% of the Authorized Control Level.

The National Association of Insurance Commissioners has adopted rules which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of December 31, 2008, each of our health plans were in compliance with the risk-based capital requirements enacted in those states.

RECENT ACCOUNTING PRONOUNCEMENTS

In December 2007, the Financial Accounting Standards Board, or FASB, issued FASB Statement No.141 (revised 2007), Business Combinations. The purpose of issuing the statement was to replace current guidance in FASB Statement No.141, Business Combinations, to better represent the economic value of a business combination transaction. The changes to be effected with FASB Statement No. 141R from the current guidance include, but are not limited to: (1) acquisition costs will be recognized separately from the acquisition; (2) known contractual contingencies at the time of the acquisition will be considered part of the liabilities acquired and and measured at their fair value; all other contingencies will be part of the liabilities acquired and measured at their fair value only if it is more likely than not that they meet the definition of a liability; (3) contingent consideration based on the outcome of future events will be recognized and measured at the time of the acquisition; (4) business combinations achieved in stages (step acquisitions) will need to recognize the identifiable assets and liabilities, as well as noncontrolling interests, in the acquiree, at the full amounts of their fair values; and (5) a bargain purchase (defined as a business combination in which the total acquisition-date fair value of the identifiable net assets acquired exceeds the fair value of the consideration transferred plus any noncontrolling interest in the acquiree) will require that excess to be recognized as a gain attributable to the acquirer. FASB Statement No. 141R will be effective for any business combinations that occur after January 1, 2009.

In December 2007, the FASB issued FASB Statement No. 160, Noncontrolling Interests in Consolidated Financial Statements, which was issued to improve the relevance, comparability, and transparency of financial information provided to investors by requiring all entities to report noncontrolling (minority) interests in subsidiaries in the same way, that is, as equity in the consolidated financial statements. Moreover, FASB Statement No. 160 eliminates the diversity that currently exists in accounting for transactions between an entity and noncontrolling interests by requiring they be treated as equity transactions. FASB Statement No. 160 will be effective January 1, 2009. The adoption of FASB Statement No. 160 will not have a material impact on our financial statements and disclosures.

We have determined that all other recently issued accounting pronouncements will not have a material impact on our consolidated financial position, results of operations and cash flows, or do not apply to our operations.

CRITICAL ACCOUNTING POLICIES AND ESTIMATES

Our discussion and analysis of our results of operations and liquidity and capital resources are based on our consolidated financial statements which have been prepared in accordance with GAAP. In connection with the preparation of our consolidated financial statements, we are required to make assumptions and estimates about future events, and apply judgments that affect the reported amounts of assets, liabilities, revenue, expenses, and the related disclosures. We base our assumptions, estimates and judgments on historical experience, current trends and other factors we believe to be relevant at the time we prepared our consolidated financial statements. On a regular basis, we review the accounting policies, assumptions, estimates and judgments to ensure that our consolidated financial statements are presented fairly and in accordance with GAAP. However, because future events and their effects cannot be determined with certainty, actual results could differ from our assumptions and estimates, and such differences could be material.

The preparation of our consolidated financial statements in conformity with GAAP requires us to make estimates and assumptions. These estimates and assumptions affect the reported amounts of assets and liabilities and the disclosures of contingent assets and liabilities as of the date of the financial statements, and the reported amounts of revenues and

expenses during the reporting periods. Future events and their effects cannot be predicted with certainty, and accordingly, our accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of our consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained and as our operating environment changes. We evaluate and update our assumptions and estimates on an ongoing basis and may employ outside experts to assist in our evaluations. Actual results could differ from the estimates we have used.

Our significant accounting policies are more fully described in Note 2, Summary of Significant Accounting Policies, to our consolidated financial statements included elsewhere herein. Our accounting policies regarding medical claims liability and intangible assets are particularly important to the portrayal of our financial position and results of operations and require the application of significant judgment by our management. As a result, they are subject to an inherent degree of uncertainty. We have reviewed these critical accounting policies and related disclosures with the Audit Committee of our board of directors.

Medical claims liability

Our medical claims liability includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. We estimate our medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

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Actuarial Standards of Practice generally require that the medical claims liability estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amounts ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. We include in our IBNR an estimate for medical claims liability under moderately adverse conditions which represents the risk of adverse deviation of the estimates in our actuarial method of reserving.

We use our judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions we consider when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims.

We apply various estimation methods depending on the claim type and the period for which claims are being estimated. For more recent periods, incurred non-inpatient claims are estimated based on historical per member per month claims experience adjusted for known factors. Incurred hospital inpatient claims are estimated based on known inpatient utilization data and prior claims experience adjusted for known factors. For older periods, we utilize an estimated completion factor based on our historical experience to develop IBNR estimates. The completion factor is an actuarial estimate of the percentage of claims incurred during a given period that have been received or adjudicated as of the reporting period to the estimate of the total ultimate incurred costs. When we commence operations in a new state or region, we have limited information with which to estimate our medical claims liability. See “Risk Factors – Failure to accurately predict our medical expenses could negatively affect our financial position, results of operations or cash flows.” These approaches are consistently applied to each period presented.

Additionally, we contract with independent actuaries to review our estimates on a quarterly basis. The independent actuaries provide us with a review letter that includes the results of their analysis of our medical claims liability. We do not solely rely on their report to adjust our claims liability. We utilize their calculation of our claims liability only as additional information, together with management’s judgment to determine the assumptions to be used in the calculation of our liability for claims.

Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as additional claims receipts and payment information becomes available. As more complete claim information becomes available, we adjust the amount of the estimates, and include the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, our operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. We consistently apply our reserving methodology from period to period. As additional information becomes known to us, we adjust our actuarial model accordingly to establish medical claims liability estimates.

The completion factor, claims per member per month and per diem cost trend factors are the most significant factors affecting the IBNR estimate. The following table illustrates the sensitivity of these factors and the estimated potential impact on our operating results caused by changes in these factors based on December 31, 2008 data:

Completion Factors (1):		Cost Trend Factors (2):	
(Decrease) Increase in Factors	Increase (Decrease) in	(Decrease) Increase in Factors	Increase (Decrease) in Medical Claims

	Medical Claims Liabilities (in thousands)		Liabilities (in thousands)
(3)%	$ 68,400	(3)%	$ (17,700)
(2)	45,100	(2)	(11,900)
(1)	22,400	(1)	(5,900)
1	(21,900)	1	5,900
2	(43,300)	2	12,000
3	(64,300)	3	18,100

(1) Reflects estimated potential changes in medical claims liability caused by changes in completion factors.
(2) Reflects estimated potential changes in medical claims liability caused by changes in cost trend factors for the most recent periods.

While we believe our estimates are appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. For example, a 1% increase or decrease in our estimated medical claims liability would have affected net earnings by $2.3 million for the year ended December 31, 2008. The estimates are based on our historical experience, terms of existing contracts, our observance of trends in the industry, information provided by our providers and information available from other outside sources, as appropriate.

The change in medical claims liability is summarized as follows (in thousands):

	Year Ended December 31,		
	2008	2007	2006
Balance, January 1	$ 313,364	$ 232,496	$ 123,102
Acquisitions	15,398	—	1,788
Incurred related to:			
Current year	2,659,036	2,212,901	1,450,116
Prior years	(18,701)	(22,003)	(13,745)
Total incurred	2,640,335	2,190,898	1,436,371
Paid related to:			
Current year	2,303,473	1,902,610	1,220,872
Prior years	292,587	207,420	107,893
Total paid	2,596,060	2,110,030	1,328,765
Balance, December 31	$ 373,037	$ 313,364	$ 232,496
Claims inventory, December 31	269,300	323,200	389,100
Days in claims payable 1	48.5	48.3	46.0

1 Days in claims payable is a calculation of medical claims liability at the end of the period divided by average expense per calendar day for the fourth quarter of each year.

The acquisition in 2008 includes reserves acquired in connection with our acquisition of Celtic. The acquisition in 2006 includes reserves acquired in connection with our acquisition of OptiCare.

Medical claims are usually paid within a few months of the member receiving service from the physician or other healthcare provider. As a result, the liability generally is described as having a "short-tail," which causes less than 5% of our medical claims liability as of the end of any given year to be outstanding the following year. We believe that substantially all the development of the estimate of medical claims liability as of December 31, 2008 will be known by the end of 2009.

Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. Changes in medical utilization and cost trends and the effect of medical management initiatives may also contribute to changes in medical claim liability estimates. While we have evidence that medical management initiatives are effective on a case by case basis, medical management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care, or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the medical management initiative are not known by us. Additionally, certain medical management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the medical management initiative changed the behavior cannot be determined. Because of the complexity of our business, the number of states in which we operate, and the volume of claims that we process, we are unable to practically quantify the impact of these initiatives on our changes in estimates of IBNR.

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The following medical management initiatives may have contributed to the favorable development through lower medical utilization and cost trends:

- Appropriate leveling of care for neonatal intensive care unit (NICU) hospital admissions, other inpatient hospital admissions, and observation admissions, in accordance with Interqual criteria.
- Tightening of our pre-authorization list and more stringent review of durable medical equipment (DME) and injectibles.
- Emergency department (ED) program designed to collaboratively work with hospitals to steer non-emergency care away from the costly ED setting (through patient education, on-site alternative urgent care settings, etc.)
- Increase emphasis on case management and clinical rounding where case managers are nurses or social workers who are employed by the health plan to assist selected patients with the coordination of healthcare services in order to meet a patient's specific healthcare needs.
- Incorporation of disease management which is a comprehensive, multidisciplinary, collaborative approach to chronic illnesses such as asthma.

Goodwill and Intangible Assets

We have made several acquisitions that have resulted in our recording of intangible assets. These intangible assets primarily consist of customer relationships, purchased contract rights, provider contracts, trade names and goodwill. At December 31, 2008, we had $163.4 million of goodwill and $17.6 million of other intangible assets.

Intangible assets are amortized using the straight-line method over the following periods:

Intangible Asset	Amortization Period
Purchased contract rights	5 – 10 years
Provider contracts	5 – 10 years
Customer relationships	5 – 15 years
Trade names	20 years

Our management evaluates whether events or circumstances have occurred that may affect the estimated useful life or the recoverability of the remaining balance of goodwill and other identifiable intangible assets. If the events or circumstances indicate that the remaining balance of the intangible asset or goodwill may be impaired, the potential impairment will be measured based upon the difference between the carrying amount of the intangible asset or goodwill and the fair value of such asset. Our management must make assumptions and estimates, such as the discount factor, future utility and other internal and external factors, in determining the estimated fair values. While we believe these assumptions and estimates are appropriate, other assumptions and estimates could be applied and might produce significantly different results.

Goodwill is reviewed every year during the fourth quarter for impairment. In addition, an impairment analysis of intangible assets would be performed based on other factors. These factors include significant changes in membership, state funding, medical contracts and provider networks and contracts.

In November 2008, as a result of our decision to divest the New Jersey health plan, we concluded it was necessary to conduct an impairment analysis of the identifiable intangible assts. As a result of the analysis and expected selling

price, we determined that the identifiable intangible assets were not impaired.

In August 2006, FirstGuard Health Plan Kansas, Inc., or FirstGuard Kansas, our wholly owned subsidiary, received notification from the Kansas Health policy Authority that its Medicaid contract scheduled to terminate December 31, 2006 would not be renewed. As a result of these events, we concluded it was necessary to conduct an impairment analysis of the identifiable intangible assets and goodwill of the FirstGuard reporting unit, which encompasses both the Kansas and Missouri FirstGuard health plans. The fair value of our FirstGuard reporting unit was determined using discounted expected cash flows and estimated market value. The impairment analysis resulted in a total non-cash intangible asset impairment charge of $87.1 million, consisting of $81.1 million of goodwill and $6.0 million of other identifiable intangible assets, which was recorded in discontinued operations in the consolidated statement of operations for the year ended December 31, 2006.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

INVESTMENTS

As of December 31, 2008, we had short-term investments of $109.4 million and long-term investments of $341.7 million, including restricted deposits of $9.3 million. The short-term investments generally consist of highly liquid securities with maturities between three and 12 months. The long-term investments consist of municipal, corporate and U.S. Agency bonds, life insurance contracts, U.S. Treasury investments and equity securities and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long-term regardless of the contractual maturity date. Our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2008, the fair value of our fixed income investments would decrease by approximately $6.2 million. Declines in interest rates over time will reduce our investment income. For a discussion of the interest rate risk that our investments are subject to, see "Risk Factors–Risks Related to Our Business–Our investment portfolio may suffer losses from reductions in market interest rates and changes in market conditions which could materially and adversely affect our results of operations or liquidity."

INFLATION

While the inflation rate in 2008 for medical care costs was slightly less than that for all items, historically inflation for medical care costs has generally exceeded that for all items. We use various strategies to mitigate the negative effects of healthcare cost inflation. Specifically, our health plans try to control medical and hospital costs through our state savings initiatives and contracts with independent providers of healthcare services. Through these contracted care providers, our health plans emphasize preventive healthcare and appropriate use of specialty and hospital services.

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

Item 8. Financial Statements and Supplementary Data

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Centene Corporation:

We have audited the accompanying consolidated balance sheets of Centene Corporation and subsidiaries as of December 31, 2008 and 2007, and the related consolidated statements of operations, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2008. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Centene Corporation and subsidiaries as of December 31, 2008 and 2007, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2008, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Centene Corporation's internal control over financial reporting as of December 31, 2008, based on criteria established in Internal Control - Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated February 22, 2009 expressed an unqualified opinion on the effectiveness of the operation of internal control over financial reporting.

(signed) KPMG LLP

St. Louis, Missouri
February 22, 2009
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CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS
(In thousands, except share data)

	December 31, 2008	2007
ASSETS		
Current assets:		
Cash and cash equivalents of continuing operations	$ 370,999	$ 267,305
Cash and cash equivalents of discontinued operations	8,100	1,279
Total cash and cash equivalents	379,099	268,584
Premium and related receivables, net of allowance for uncollectible accounts of $595 and $258, respectively	92,531	79,492
Short-term investments, at fair value (amortized cost $108,469 and $46,193, respectively)	109,393	46,074
Other current assets	75,333	39,382
Current assets of discontinued operations other than cash	9,987	12,807
Total current assets	666,343	446,339
Long-term investments, at fair value (amortized cost $329,330 and $314,681, respectively)	332,411	317,041
Restricted deposits, at fair value (amortized cost $9,124 and $6,383, respectively)	9,254	6,430
Property, software and equipment, net	175,858	135,883
Goodwill	163,380	138,862
Intangible assets, net	17,575	11,337
Other long-term assets	59,083	36,067
Long-term assets of discontinued operations	27,248	29,865
Total assets	$ 1,451,152	$ 1,121,824
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$ 373,037	$ 313,364
Accounts payable and accrued expenses	219,566	102,944
Unearned revenue	17,107	44,016
Current portion of long-term debt	255	971
Current liabilities of discontinued operations	31,013	25,505
Total current liabilities	640,978	486,800
Long-term debt	264,637	206,406
Other long-term liabilities	43,539	13,300
Long-term liabilities of discontinued operations	726	271
Total liabilities	949,880	706,777
Commitments and contingencies		
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; issued and outstanding 42,987,764 and 43,667,837 shares, respectively	43	44
Additional paid-in capital	222,841	221,693
Accumulated other comprehensive income:		

Unrealized gain on investments, net of tax	3,152	1,571
Retained earnings	275,236	191,739
Total stockholders' equity	501,272	415,047
Total liabilities and stockholders' equity	$ 1,451,152	$ 1,121,824

The accompanying notes to the consolidated financial statements are an integral part of these statements.

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CENTENE CORPORATION AND SUBSIDIARIES

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

	Year Ended December 31,		
	2008	2007	2006
Revenues:			
Premium	$ 3,199,360	$ 2,611,953	$ 1,707,439
Premium tax	90,202	76,567	35,848
Service	74,953	80,508	79,159
Total revenues	3,364,515	2,769,028	1,822,446
Expenses:			
Medical costs	2,640,335	2,190,898	1,436,371
Cost of services	56,920	61,348	60,287
General and administrative expenses	444,733	384,970	267,712
Premium tax	90,966	76,567	35,848
Total operating expenses	3,232,954	2,713,783	1,800,218
Earnings from operations	131,561	55,245	22,228
Other income (expense):			
Investment and other income	21,728	24,452	15,511
Interest expense	(16,673)	(15,626)	(10,574)
Earnings from continuing operations before income tax expense	136,616	64,071	27,165
Income tax expense	52,435	23,031	9,565
Net earnings from continuing operations	84,181	41,040	17,600
Discontinued operations, net of income tax (benefit) expense of $(281), $(31,563), and $12,412	(684)	32,362	(61,229)
Net earnings (loss)	$ 83,497	$ 73,402	$ (43,629)
Net earnings (loss) per share:			
Basic:			
Continuing operations	$ 1.95	$ 0.95	$ 0.41
Discontinued operations	(0.02)	0.74	(1.42)
Basic earnings (loss) per common share	$ 1.93	$ 1.69	$ (1.01)
Diluted:			
Continuing operations	$ 1.90	$ 0.92	$ 0.39
Discontinued operations	(0.02)	0.72	(1.37)
Diluted earnings (loss) per common share	$ 1.88	$ 1.64	$ (0.98)
Weighted average number of shares outstanding:			
Basic			