CENTENE Corporation

a proven year... a solution for healthcare >>>

2002 annual report

This year's annual report is dedicated to Howard E. Cox, Jr., a member of our board of directors from 1993 to 2003, whose support, confidence and perseverance helped the company to reach where it is today.

mission

Centene will be a recognized market leader in government-supported, physician-driven healthcare, creating enhanced value through positive outcomes for our members and clients.

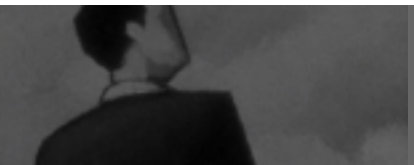
Annual Report History

FINANCIAL HIGHLIGHTS

Year ended December 31,

(in thousands, except membership and per share data)

	1998	1999	2000	2001	**2002**
Membership	135,600	142,300	194,200	235,100	**409,600**
Revenue	$150,438	$201,429	$221,350	$326,569	**$461,487**
Earnings from operations	$ (6,827)	$ (6,612)	$ 6,520	$ 18,472	**$ 31,606**
EPS	$ (6.78)	$ (10.99)	$ 1.13	$ 1.61	**$ 2.20**



DEAR SHAREHOLDERS,

AT CENTENE, OUR CORE BELIEF HAS ALWAYS BEEN THAT EVERY AMERICAN IS ENTITLED TO RECEIVE QUALITY HEALTHCARE WITH DIGNITY. AS SUCH, OUR HEALTH PLANS AND CARE COORDINATION PROGRAMS SPECIFICALLY TARGET THE MEDICAID POPULATION, WHICH HISTORICALLY HAS BEEN UNDERSERVED. WE BELIEVE THAT OUR FOCUSED APPROACH WILL ENABLE US TO ACHIEVE STEADY GROWTH WHILE GENERATING STABLE MARGINS.

delivering

"In today's difficult economic climate, we remain the solution for the states, working successfully to save them money and enabling better health outcomes for their Medicaid recipients."

The year 2002 was further proof that the managed Medicaid model works. During our first full year operating as a public company, we achieved our internal goals of strong financial performance. This was accomplished by solid organic growth and execution of our stated acquisition strategy, highlighted by our entry into New Jersey. We did this while accomplishing our mission of saving states money while improving health outcomes with quality care for our recipients. At Centene, we consider healthcare an entitlement that every American has a right to receive with dignity. We believe that healthcare is most successfully delivered where it may best be measured—in the local marketplace. Therefore, we distinguish ourselves through our local approach, which encompasses local branding, locally managed call centers and strong relationships with physicians, holding them accountable for the quality of care delivered.

We are focused on managed Medicaid and Medicaid-related products. The three key populations served include Temporary Assistance for Needy Families (TANF) and State Children's Health Insurance Programs (SCHIP), which are characterized by a predominance of women and children, and Supplemental Security Income (SSI), designed to help the aged, blind and disabled.

The Medicaid managed care industry remains very attractive to us. It is estimated by the Centers for Medicare and Medicaid Services (CMS) that this industry will grow substantially, from $225 billion today to over $444 billion by 2010. We are poised to take advantage of this opportunity by adding new member lives into our programs while reducing excessive spending and being interdictive in the management of care.

We recognize that states have budget issues, and regard this as an opportunity to constructively restructure the allocation of benefits to maximize the number of people whose care these basic benefits cover. We support the federal alternative to give states more flexibility in managing their social services budgets. Centene is a company that has successfully worked through turbulent times in the past with the states, only to emerge stronger. We fundamentally believe the states in which we operate realize that the continued enrollment of recipients into managed Medicaid programs delivers higher quality of care and is more cost effective than using fee-for-service care. We choose to operate only in mandated Medicaid states, which we believe are more fiscally responsible and offer the most substantial opportunities for working constructively with the industry. Importantly, whether operating in prosperous or difficult economic times, Centene continues to be the solution for states seeking to manage their fiscal budgets.

Two noteworthy studies conducted by Milliman USA and the Urban Institute Health Policy Center concretely point to the ongoing savings states are able to realize by enrolling recipients in managed Medicaid programs. The Milliman USA study, conducted in Wisconsin in 2001, demonstrated that the managed Medicaid industry estimated saving the state $56 million in 2002, an increase of 45% over 2001. According to state data, savings in 2002 in Texas and New Jersey are both estimated at $30 million, and savings are estimated at $9 million in Indiana, each of which represents an improvement over 2001 levels. Beginning in 2003, we will provide report cards to our states, measuring our performance and the fiscal benefits of working with Centene. We will continue to work proactively and responsibly with the states in which we operate to ensure ongoing cost savings and convey the benefits of enrolling recipients in managed Medicaid programs.

We are proud of the progress we made during the last year in bringing new recipients into our programs. We closed 2002 with 409,600 lives, an annual increase of 74% that we achieved through a combination of record unit membership growth and important acquisitions and alliances. These transactions not only expanded our positions in existing markets, but gave us a presence in new markets. In September we acquired 24,000 SCHIP lives in Texas, increasing our market positions in San Antonio and El Paso while entering two new service areas, Amarillo and Lubbock. We entered our fourth state, New Jersey, through a joint venture with the University of Medicine and Dentistry of New Jersey (UMDNJ), adding approximately 52,000 Medicaid members in 15 counties throughout the state. With 685,000 Medicaid participating lives in this market, we anticipate future organic growth in New Jersey.

At Centene, we measure our success using a number of metrics. For example, we work diligently to maintain our physicians' satisfaction by being sensitive to the timely payment and processing of claims. The number of days in claims payable on hand continued to decline in 2002 to 71.8 days from 73.4 days a year ago, proof of our efficient management of the claims payment process. Another way that we ensure access to and quality of care is by carefully monitoring complaint ratios regarding our services to providers and patients. Furthermore, our margin protection programs are critical to ensuring that our business model remains predictable and profitable. Through the combination of emergency room policy changes, aimed at reducing inappropriate utilization and frequent visits to the ER, and rate increases of a blended 5.1% across all of our states in 2002, we believe that we have developed the standard for a business model that works.

Other important milestones marked 2002. We concluded a successful secondary offering of 5.75 million shares, enabling our venture capital investors to sell shares in an orderly fashion and increasing the trading liquidity of our stock. Additional noteworthy events included the expansion of our claims processing facility and significant new management appointments, both aimed to accommodate organic and acquisition-driven membership growth; and the purchase of Bankers Reserve Life Insurance of Wisconsin to sell reinsurance solely to our health plan subsidiaries. We will use this entity to consolidate the risk of our health plans, thereby allowing us to provide improved levels of insurance without changing the overall risk profile of our consolidated operations. This enables us to reduce our reinsurance costs and receive recognition for such in the state in which we operate.

We were very proud of our 2002 results, highlighted by a 41.3% increase in revenue to $461.5 million and fully diluted earnings per share of $2.20, an increase of 36.6%. These metrics, in combination with a solid increase in

membership marked our 14th consecutive quarter of growth. Operating cash flow remained strong at $39.7 million, an increase of 31.4%. We are pleased to report that our health benefits ratio (HBR) continued to improve and remains within our targeted banded range of 82.0% to 83.5% of revenues. Our SG&A showed sustained decreases; moving toward our goal to have our SG&A ratio in single digits by the fourth quarter of 2003. The balance sheet remains healthy with $164.7 million in cash and investments and no debt. Finally, we continued to build the required infrastructure to enhance our information systems platform, which has the capacity to handle in excess of 1 million lives.

As we enter 2003, we will continue to work with our states to deliver cost-effective, quality healthcare and will remain focused on the opportunities that exist in mandatory states. There are 37 mandatory states, 25 of which are of interest to us. We have a full pipeline of acquisition targets and will continue to be disciplined, prudent purchasers, focusing on accretive opportunities. We delivered on our promise to enter a new state in 2002 and expect to continue to target attractive market opportunities. Concurrent with this aggressive acquisition program, we will strengthen staffing to further accelerate our efforts.

In addition, we will evaluate opportunities to diversify our revenue base and expand our product offering, particularly in fee-for-service Medicaid-related products. The behavioral health arena is a good example. Today, 6% of all ambulatory care is behavioral health related and, therefore, the potential to affect this cost center and manage the care of this patient group is significant. We look forward to updating you on our progress in this area in due course.

At Centene, our approach is to achieve predictable and consistent results. In 2002, we accomplished those goals and, we believe that we have the winning formula for continued success in the managed Medicaid industry. Our solid financial performance along with a carefully planned growth strategy provide a solid foundation for continued strong performance.

Our achievements would not be possible without the dedication and hard work of all the employees at Centene. I would personally like to thank them for their ongoing commitments and contributions.

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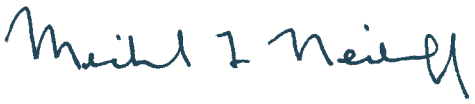
Sincerely,



MICHAEL F. NEIDORFF
President and Chief Executive Officer

T E A M W O R K

AT CENTENE, OUR UNIFIED LEADERSHIP TEAM IS COMMITTED TO DELIVERING BETTER HEALTHCARE FOR OUR CONSTITUENCY. WE FIRMLY BELIEVE THAT QUALITY HEALTHCARE IS AN AMERICAN ENTITLEMENT AND HAVE SUCCESSFULLY BUILT OUR BUSINESS ON DELIVERING THAT PROMISE.

leadership

Our successes have been predicated on remaining predictable to the people to whom we are accountable, which includes our providers, members, states, employees and shareholders.

Our commitment to the advancement of employees from within was highlighted this year by several noteworthy promotions. Carol Goldman was promoted from her position as Director of Human Resources (Plans) and is now Vice President and Chief Administrative Officer; Cary Hobbs was promoted from Director of Business Implementation to Vice President of Strategy and Business Implementation; Jim Reh was Director of IT & Facilities and is now Vice President of Facilities Management; Cindy Jansky, formerly Director of Human Resources, is now Vice President of Human Resources; and Judy Bauer was promoted from Director of Medical Management to Vice President of Care Management.

In addition to recognizing talent within our organization, we seek the best in the industry to join Centene. To execute our growth strategy, we have significantly strengthened the management team with the addition of several highly qualified and experienced senior managed care executives.

Christopher Bowers—Since entering the Texas market two years ago, we have achieved significant membership growth. To support this growth, Christopher Bowers was appointed as President and Chief Executive Officer of Superior HealthPlan in Texas. We expect that Chris' expertise in managing Medicaid managed care operations and government programs will help us to attain this important goal.

Jesse N. Hunter—Given that one of Centene's key goals is to diversify the business and increase market share, we hired Jesse Hunter as our Manager of Mergers and Acquisitions. We believe that Jesse's solid background in building managed care partnerships and collaborations will be a great asset to the company.

Daniel R. Paquin—As part of our effort to manage the integration of newly acquired plans and organize start-up operations in new markets, we appointed Daniel Paquin as Senior Vice President of our Health Plan Business Group. Dan has extensive experience in the development and management of Medicaid plans across diverse markets, including New Jersey, our newest market.

John D. Tadich—In addition to evaluating new market opportunities for diversification and expansion, we are also looking to broaden our service offerings in Medicaid and Medicaid-related products such as behavioral health and NurseWise[SM]. To this end, we hired John Tadich, a 25-year veteran of the managed care industry with a focus in specialty companies, to the newly created position of Senior Vice President of Specialty Companies.

We are pleased to have these quality individuals on our team. As we grow, we will seek further opportunities to build and retain our leadership team.

>>> solution for the recipients

>>>
solution for
the local communities

LOCAL RECOGNITION

OUR "LOCAL APPROACH" DISTINGUISHES CENTENE IN ITS MARKETS. BY PROVIDING ACCESS TO OUR HEALTHCARE SERVICES THROUGH A LOCAL NETWORK OF PHYSICIANS WHO UNDERSTAND THE CULTURAL NORMS OF THEIR COMMUNITIES, WE HAVE ACHIEVED A HIGH DEGREE OF SUCCESS IN OUR SERVICE AREAS.

commitment

While Centene is a national company, we firmly believe that healthcare is local, touching regulators, healthcare providers, government officials and patients. To maximize awareness in each of our markets, we operate our health plans under brand names unique to each market and have developed and maintain a number of widely recognized and highly visible local programs. For example, we use local call centers for member and provider relations. Our goal is to be indigenous to the markets in which we operate and embraced as the hometown solution.

Central to our approach is our network of physicians who establish local policies and practices in our markets. This serves to build recognition of Centene's health services within each of our respective markets. These physicians have significant representation on our local boards of directors and, through organized committees, drive how healthcare is provided in their communities. Furthermore, we developed these committees, which are led by our physician members, to review physician credentials, quality management programs, utilization review policies and physician compensation programs and policies.

As a result of their active involvement in developing and implementing our healthcare delivery policies, the physicians are committed and loyal to Centene. We recognize the importance of protecting provider cash flow and consistently pay claims with one of the best records in the industry. We will continue to strengthen these relationships through continued timely payments and reduction of the cumbersome policies that are not conducive to better outcomes.

We support our local health plan operations with centralized finance, information, claims and medical management support systems. This enables us to achieve greater utilization and cost controls that have lead to continuously improved outcomes.

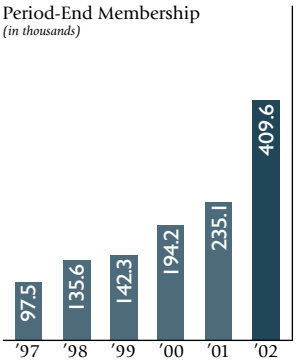
We believe that our obligation is to be a low cost provider, establishing reasonable plan and administrative margins in order to maintain appropriate financial viability for the states in which we operate. One key measurement of our commitment to maximizing benefits to our recipients while keeping healthcare costs down and improving the quality of services provided is our health benefits ratio, which we maintain in a targeted range of 82.0% to 83.5% for the SCHIP and TANF business. For the year ended December 31, 2002, our health benefits ratio was 82.3%.

The end of 2002 marked our eighth consecutive quarter of declining SG&A ratio, from 13.7% in the fourth quarter of 2000 to 10.8% in the fourth quarter of 2002. Importantly, we calculate this ratio conservatively and do not include interest income in the revenue line. We believe that our highly scaleable platform gives us the ability to rapidly expand membership at a relatively low incremental cost. Our goal is to achieve a single digit SG&A ratio by the fourth quarter of 2003 for our current TANF and SCHIP population.

PREDICTABILITY

OUR YEAR-END RESULTS REAFFIRM THE CONSISTENCY, PREDICTABILITY AND SUSTAINABILITY OF THE CENTENE BUSINESS MODEL. WE REMAIN TRUE TO OUR FOCUS OF BEING A PREDICTABLE COMPANY DELIVERING ON ITS PROMISES AND STATED EXPECTATIONS.

results

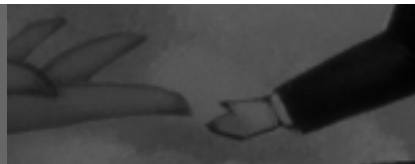


One year following our initial public offering, we are proud to say that we are successfully fulfilling our mission to deliver better healthcare to our recipients while providing the solution for states to manage their Medicaid costs.

We remain committed to the execution of our threefold strategy: 1) to evaluate new market opportunities for diversification and expansion of our business, 2) to grow organically and 3) to pursue opportunities in Medicaid and Medicaid-related products such as behavioral health and NurseWise.℠

There are significant organic growth opportunities in our current markets. In our New Jersey market, for example, there are approximately 685,000 Medicaid lives, 52,000 of which are served by University Health Plans, Inc. and similar prospects exist in our three other states to capture additional unit growth. Additionally, we will continue to make prudent and disciplined acquisitions based upon strict criteria and focus on markets where we believe Centene can be the market leader in its contracted service area.

We believe that part of predictability is accountability. This year, we will be issuing each of our states a report card giving both qualitative and quantitative assessments of our performance. This will include matrices focused on quality-of-care and efficiency of claims payments as well as data on the cost savings over traditional fee-for-service in the Medicaid population. Importantly, third parties will compile this data, increasing the objectivity and credibility of the matrices and their conclusions. We believe this increased accountability will help us deliver even better results going forward.



> > >
solution for delivering care

> > >
solution for promoting wellness

OUTREACH

WE ARE A MEDICAID MANAGED CARE COMPANY, ENCOMPASSING THREE KEY POPULATIONS: TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF), SUPPLEMENTAL SECURITY INCOME (SSI) AND STATE CHILDREN'S HEALTH INSURANCE PROGRAMS (SCHIP). OUR FOCUSED BUSINESS MODEL ENABLES US TO OFFER PROGRAMS THAT MEET THE SPECIFIC NEEDS OF THESE POPULATIONS.

Medicaid provides medical benefits and health services to low-income families and people with disabilities. It is distinct in that the majority of participants are women and children with fewer chronic conditions. As a result, the majority of Centene's programs and services emphasize family-focused care, namely obstetrics/gynecology, pediatrics and internal medicine.

We continuously refine and expand our key programs as our membership grows. These include NurseWise℠ (a toll-free phone line that our members may call for nurse assistance when they cannot reach a doctor), CONNECTIONS (an education and outreach program designed to provide our members with the medical information required in promoting preventative care), *STARTSMART* for Your Baby℠ (a telephone-based pre-natal and infant health program designed to improve access to pre-natal care and reduce birth complications) and a number of disease management programs designed to help educate our members on medical conditions such as asthma, diabetes and pregnancy. The objectives of these outreach programs are to educate members on how to access primary care and reduce inappropriate and expensive emergency room visits, thereby improving overall health outcomes and reducing costs. Initially developed to promote wellness, these programs have become additional sources of revenue for Centene.

Consistent with our strategy of becoming a multi-line Medicaid services company, we plan to expand into the behavioral health area, an underserved area in Medicaid-related products. We view this as a natural extension of our business, particularly since there is significant overlap among patient groups, and we believe that there are definite synergies with our current programs.

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QUARTERLY SELECTED FINANCIAL INFORMATION

In thousands, except share data and membership data / unaudited

	For the Quarter Ended			
	March 31, 2001	June 30, 2001	September 30, 2001	December 31, 2001
Total revenues	$70,304	$ 80,560	$ 85,414	$ 90,291
Earnings from operations	2,906	4,513	5,355	5,698
Earnings before income taxes	3,777	5,343	6,175	6,731
Net earnings	$ 2,182	$ 3,230	$ 3,563	$ 3,920
Net earnings attributable to common stockholders	$ 2,059	$ 3,107	$ 3,440	$ 3,822
Per share data:				
Earnings per common share, basic	$ 2.27	$ 3.41	$ 3.78	$ 1.37
Earnings per common share, diluted	$ 0.29	$ 0.42	$ 0.45	$ 0.45
Period end membership	205,000	213,200	224,800	235,100

	For the Quarter Ended			
	March 31, 2002	**June 30, 2002**	**September 30, 2002**	**December 31, 2002**
Total revenues	$95,753	$107,610	$116,398	$141,726
Earnings from operations	6,262	7,718	8,028	9,598
Earnings before income taxes	7,177	8,683	14,780	10,496
Net earnings	$ 4,300	$ 5,234	$ 9,273	$ 6,814
Per share data:				
Earnings per common share, basic	$ 0.43	$ 0.51	$ 0.87	$ 0.63
Earnings per common share, diluted	$ 0.38	$ 0.45	$ 0.78	$ 0.57
Period end membership	249,300	278,600	296,100	409,600

SELECTED FINANCIAL INFORMATION

	Year Ended December 31,				
	2002	2001	2000	1999	1998
	(In thousands, except share data)				
Statement of Earnings Data:					
Revenues:					
Premiums	$461,030	$326,184	$216,414	$200,549	$149,577
Administrative services fees	457	385	4,936	880	861
Total revenues	461,487	326,569	221,350	201,429	150,438
Operating expenses:					
Medical services costs	379,468	270,151	182,495	178,285	132,199
General and administrative expenses	50,413	37,946	32,335	29,756	25,066
Total operating expenses	429,881	308,097	214,830	208,041	157,265
Earnings (losses) from operations	31,606	18,472	6,520	(6,612)	(6,827)
Other income (expense):					
Investment and other income, net	9,575	3,916	1,784	1,623	1,794
Interest expense	(45)	(362)	(611)	(498)	(771)
Equity in earnings (losses) from joint ventures	—	—	(508)	3	(477)
Earnings (losses) from continuing operations before income taxes	41,136	22,026	7,185	(5,484)	(6,281)
Income tax expense (benefit)	15,631	9,131	(543)	—	(1,542)
Minority interest	116	—	—	—	—
Earnings (losses) from continuing operations	25,621	12,895	7,728	(5,484)	(4,739)
Loss from discontinued operations, net	—	—	—	(3,927)	(2,223)
Net earnings (losses)	25,621	12,895	7,728	(9,411)	(6,962)
Accretion of redeemable preferred stock	—	(467)	(492)	(492)	(122)
Net earnings (losses) attributable to common stockholders	$ 25,621	$ 12,428	$ 7,236	$ (9,903)	$ (7,084)
Net earnings (losses) from continuing operations per common share:					
Basic	$ 2.45	$ 8.97	$ 8.03	$ (6.63)	$ (4.65)
Diluted	$ 2.20	$ 1.61	$ 1.13	$ (6.63)	$ (4.65)
Net earnings (losses) per common share:					
Basic	$ 2.45	$ 8.97	$ 8.03	$ (10.99)	$ (6.78)
Diluted	$ 2.20	$ 1.61	$ 1.13	$ (10.99)	$ (6.78)
Weighted average common shares outstanding:					
Basic	10,477,360	1,385,399	901,526	900,944	1,044,434
Diluted	11,644,077	8,019,497	6,819,595	900,944	1,044,434
Pro forma net earnings per common share:					
Basic		$ 1.38	$ .52		
Diluted		$ 1.25	$ .52		
Pro forma weighted average common shares outstanding:					
Basic		10,049,085	10,025,885		
Diluted		11,100,319	10,069,595		

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

Overview

We provide managed care programs and related services to individuals receiving benefits under Medicaid, including Supplemental Security Income, or SSI, and the State Children's Health Insurance Program, or SCHIP. We have health plans in Wisconsin, Texas, Indiana and New Jersey.

On December 1, 2002, we acquired 80% of the outstanding capital stock of University Health Plans, or UHP, from University of Medicine and Dentistry of New Jersey, or UMDNJ, which continues to own the remaining capital stock of UHP. UHP is a managed health plan operating in 15 counties in New Jersey. We paid an aggregate purchase price of approximately $10.6 million for our interest in UHP. We entered into an investor rights agreement with UMDNJ providing that, among other things:

- We have the right, exercisable at any time prior to September 1, 2003, to purchase the remaining shares of UHP held by UMDNJ for a cash purchase price of $2.6 million.
- If we do not exercise the right described above, the remaining shares of UHP held by UMDNJ will be exchanged on December 1, 2005 for a purchase price payable in either, at our election, shares of our common stock or cash. The purchase price would equal the greater of (a) $2.6 million or (b) the product of (1) the enterprise value of UHP as of December 1, 2005 and (2) the percentage of the outstanding UHP common stock (on a fully diluted basis) then represented by the shares owned by UMDNJ.

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

Revenues

We generate revenues primarily from premiums we receive from the states in which we operate to provide health benefits to our members. We receive a fixed premium per member per month pursuant to our state contracts. We generally receive premiums during the month we provide services and recognize premium revenue during the period in which we are obligated to provide services to our members. We also generate administrative services fees for providing services to SSI members on a non-risk basis.

Premiums collected in advance are recorded as unearned premiums. Premiums due to us are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and our management's judgment on the collectibility of these accounts. As we generally receive premiums during the month in which services are provided, the allowance is typically not significant in comparison to total premium revenue and does not have a material impact on the presentation of our financial condition, changes in financial position or results of operations. From 1998 to 2000, however, we provided Medicaid services in certain regions of Indiana as a subcontractor with Maxicare Indiana, Inc. In June 2001, the Insurance Commissioner of the Indiana Department of Insurance declared Maxicare insolvent and ordered Maxicare into liquidation. As a result, we recorded an allowance for uncollectible receivables in the amount of $2.7 million to fully reserve for all receivables from Maxicare as of December 31, 2001. In 2002, subsequent to a release and settlement agreement with Maxicare and the Indiana Insurance Commissioner which requires no payment by either Maxicare or us, we wrote off the entire balance of the receivable from Maxicare as uncollectible and reduced the related allowance for doubtful accounts.

The primary driver of our increasing revenues has been membership growth. We have increased our membership through both internal growth and acquisitions. From December 31, 2000 to December 31, 2002, we increased our membership by 111%. The following table sets forth our membership by state:

	December 31,		
	2002	2001	2000
Wisconsin	133,000	114,300	60,200
Texas	118,000	54,900	26,000
Indiana	105,700	65,900	108,000
New Jersey	52,900	—	—
Total	409,600	235,100	194,200

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

	December 31,		
	2002	2001	2000
Medicaid (excluding SSI)	336,100	210,900	183,500
SCHIP	65,900	21,800	9,800
SSI	7,600	2,400	900
Total	409,600	235,100	194,200

In 2002, our membership increased by 24,000 members in Texas due to the purchase of SCHIP contract rights from Texas University Health Plan. In addition, two smaller plans exited the Austin, Texas market. As a result, our Texas plan increased its membership by 28,000 lives. This increase includes 12,000 lives that we are managing for the state of Texas on an interim basis and that will become part of a reprocurement process scheduled for mid 2003. We entered the New Jersey market through our acquisition of 80% of the equity of UHP. Membership increases in our Wisconsin and Indiana markets resulted from additions to our provider network and growth in the number of Medicaid beneficiaries.

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

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

Operating Expenses

Our operating expenses include medical services costs and general and administrative expenses.

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

Our results of operations depend on our ability to manage expenses related to health benefits and to predict accurately costs incurred. The table below depicts our health benefits ratio, which represents medical services costs as a percentage of premium revenues and reflects the direct relationship between the premium received and the medical services provided. Our stabilization in the ratio primarily reflects improved provider contract terms, premium rate increases in our markets served and member reductions in our southern Indiana market.

	Year Ended December 31,		
	2002	2001	2000
Health benefits ratio	82.3%	82.8%	84.3%

Our general and administrative expenses primarily reflect wages and benefits and other administrative costs related to our employee base, including those fees incurred to provide services to our members. Some of these services are provided locally, while others are delivered to our health plans from a centralized location. This approach provides the opportunity to control both direct and indirect costs. The major centralized functions are claims processing, information systems, finance, medical management support and administration. The following table sets forth the general and administrative expense ratio, which represents general and administrative expenses as a percent of total revenues and reflects the relationship between revenues earned and the costs necessary to drive those revenues.

	Year Ended December 31,		
	2002	2001	2000
General and administrative expenses ratio	10.9%	11.6%	14.6%

The improvement in the general and administrative expenses ratio reflects growth in membership and leveraging of our overall infrastructure. For example, the decrease in our general and administrative ratio over the past two years in part reflects our efforts to increase claims processing efficiencies through our centralized support functions. As a result, our days in claims payable, which is a calculation of

medical claims liabilities at the end of the quarter divided by average claims expense per calendar day for such quarter, decreased from 73.4 days at December 31, 2001 to 71.8 at December 31, 2002. Net of the effects of our acquisition of 80% of the capital stock of UHP on December 1, 2002, our days in claims payable at December 31, 2002 would have been 64.5 days.

Other Income (Expense)

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

- Investment income is derived from our cash, cash equivalents and investments. Information about our investments is presented below under "Liquidity and Capital Resources."
- Interest expense reported in 2002 represents commitment fees paid to a bank in conjunction with our undrawn credit facility. Interest expense reported in 2001 and 2000 primarily reflected interest paid on our subordinated notes, which we repaid in full in December 2001.
- Equity in earnings (losses) from joint ventures principally represented our share of operating results from Superior HealthPlan, which we formed with Community Health Centers Network in 1997. From 1998 through 2000, we owned 39% of Superior, and therefore accounted for the investment under the equity method of accounting. Effective January 1, 2001, we entered into an agreement to purchase an additional 51% of Superior. We also agreed to purchase from TACHC GP, Inc. a term note pursuant to which Superior owed TACHC $160,000. As a result of entering into this agreement, we began accounting for our investment in Superior using consolidation accounting. We therefore no longer reflect any operations of Superior in equity in earnings (losses) from joint ventures and we eliminate in consolidation all administrative fees from Superior. In addition, in December 2001, we acquired the remaining 10% equity interest in Superior in exchange for 7,143 shares of our common stock.

Critical Accounting Policies

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

Medical Claims Liabilities

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

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

The change in medical claims liabilities is summarized as follows:

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

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

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

Intangible Assets
We have made several acquisitions over the past two years that collectively have resulted in our recording of a significant amount of intangible assets. These intangible assets represent the excess of cost over the fair market value of net assets acquired in purchase transactions and consist of purchased contract rights, provider contracts and goodwill. Purchased contract rights are amortized using the straight-line method over periods ranging from 60 to 120 months. Provider contracts are amortized using the straight-line method over 120 months.

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

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

Results of Operations

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

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

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

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

General and administrative expenses for the year ended December 31, 2002 increased $12.5 million, or 32.9%, to $50.4 million from $37.9 million in 2001. This increase reflected a higher level of wages and related expenses for additional staff to support our membership growth.

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

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

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

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

membership growth, net of the termination of our Indiana subcontract arrangement.

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

Operating Expenses

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

General and administrative expenses for the year ended December 31, 2001 increased $5.6 million, or 17.4%, to $37.9 million from $32.3 million in 2000. This increase primarily was due to a higher level of wages and related expenses for additional staff to support our membership growth.

Other Income

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

Income Tax Expense

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

Liquidity and Capital Resources

On May 22, 2002, we closed a follow-on public offering of 5,000,000 shares of common stock at $24.75 per share. Of the 5,000,000 shares, 4,600,000 shares were offered by selling stockholders and 400,000 by us. On June 5, 2002, the underwriters of our follow-on public offering exercised their over-allotment option to purchase 679,505 additional shares from selling stockholders and 70,495 shares from us. We received net proceeds of $10.3 million from the two closings of the follow-on offering.

On December 18, 2001, we closed our initial public offering of 3,250,000 shares of common stock at $14.00 per share. We received net proceeds of $41.0 million. Prior to this offering, we financed our operations and growth through private equity and debt financings and internally generated funds, raising $22.4 million between 1993 and 1998. This consisted of $18.4 million through the issuance of equity securities and $4.0 million through subordinated debt financing.

Our operating activities provided cash of $13.5 million in 2000, $30.2 million in 2001 and $39.7 million in 2002. The increases in 2001 and 2002 were due to further improved profitability, an increase in membership and the timing of capitation payments.

Our investing activities used cash of $14.6 million in 2000, provided cash of $2.7 million in 2001 and used cash of $79.7 million in 2002. Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets within our investment guidelines. Net cash provided by and used in investing activities will fluctuate from year to year due to the timing of investment purchases, sales and maturities. As of December 31, 2002, our investment portfolio consisted primarily of fixed-income securities with an average duration of 3.3 years. Cash is invested in investment vehicles such as municipal bonds, commercial paper, U.S. government-backed agencies and U.S. Treasury instruments. The states in which we operate prescribe the types of instruments in which our subsidiaries may invest their cash. The average portfolio yield was 5.6% as of December 31, 2001 and 6.9% as of December 31, 2002, exclusive of a one-time dividend of $5.1 million from a captive insurance company in which we maintained an investment.

Our financing activities used cash of $2.4 million in 2000 and provided cash of $37.0 million in 2001 and $10.8 million in 2002. During 2000, financing cash flows consisted of borrowings and repayments under a credit facility and issuances of preferred stock. During 2001, financing cash flows primarily consisted of the issuance of common stock through our initial public offering net of the repayment of subordinated notes with $4.0 million of our proceeds. During 2002, financing cash flows primarily consisted of the issuance of common stock through our follow-on offering, the exercise of the over-allotment and proceeds received from the exercise of stock options.

We may use our existing funds, including proceeds from our two public offerings, to make strategic acquisitions including Medicaid and SCHIP businesses, contract rights and related assets to increase our membership and to expand our business into new service areas. In 2002, we purchased the capital stock of Bankers Reserve Life Insurance Company

of Wisconsin for $479,000, net of assets and liabilities acquired, and the rights to Texas Universities Health Plan's SCHIP contracts for $595,000. In addition, we purchased 80% of the outstanding capital stock of UHP for $10.6 million. In 2001, we purchased the rights to the Humana Medicaid contracts with the states of Texas and Wisconsin for $1.2 million. In 2002, we spent $3.9 million on capital assets consisting primarily of new software, software and hardware upgrades, furniture, equipment and leasehold improvements related to office and market expansions. In 2001, we purchased $3.6 million of furniture, equipment and leasehold improvements due to the addition of the Austin and San Antonio markets and the expansion of the Wisconsin market. We anticipate spending $7.3 million on additional capital expenditures in 2003 related to office and market expansions and system upgrades.

Our principal contractual obligations at December 31, 2002 consisted of obligations under operating leases. The significant annual noncancelable lease payments over the next five years and beyond are as follows (in thousands):

	Payment Due
2003	$ 3,241
2004	3,124
2005	3,026
2006	2,661
2007	2,396
Thereafter	7,624
	$22,072

In addition, we will acquire the remaining equity of UHP by no later than December 1, 2005, as described under "Management's Discussion and Analysis of Financial Conditions and Results of Operations—Overview."

In May 2002, we entered into a $25 million revolving line of credit facility with LaSalle Bank N.A. The line of credit has a term of one year and has interest rates based on prime, floating and LIBOR rates. We granted a security interest in the common stock of our subsidiaries. The facility includes financial covenants, including requirements of minimum EBITDA and minimum tangible net worth. We are required to obtain LaSalle's consent of any proposed acquisition that would result in a violation of any of the covenants contained in the line of credit. As of December 31, 2002, we were in compliance with all covenants and no funds had been drawn on the facility.

At December 31, 2002, we had working capital of $(8.8) million as compared to $35.7 million at December 31, 2001 and $(5.3) million at December 31, 2000. Our working capital is negative at times due to our efforts to increase investment returns through purchases of long-term investments, which have maturities of greater than one year and, therefore, are classified as long-term. Our investment policies are also designed to provide liquidity and preserve capital. We manage our short-term and long-term investments to ensure that a sufficient portion is held in investments that are highly liquid and can be sold to fund working capital as needed.

Cash, cash equivalents and short-term investments were $69.2 million at December 31, 2002 and $90.0 million at December 31, 2001. Long-term investments were $95.4 million at December 31, 2002 and $22.3 million at December 31, 2001, including restricted deposits of $15.8 million and $1.2 million, respectively. Cash and investments held by our unregulated entities totaled $52.0 million at December 31, 2002. Based on our operating plan, we expect that our cash, cash equivalents and investments, cash from our operations and cash available under our credit facility will be sufficient to finance our operations and capital expenditures for at least 12 months from the date of this report.

Regulatory Capital and Dividend Restrictions

Our operations are conducted through our subsidiaries, most of which 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.

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, 2002, our subsidiaries had aggregate statutory capital and surplus of $36.9 million, compared with the required minimum aggregate statutory capital and surplus of $22.0 million.

The National Association of Insurance Commissioners adopted guidelines which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. Wisconsin and Texas adopted various forms of the rules as of December 31, 1999. As of December 31, 2002 our Wisconsin and Texas health plans were in compliance with risk-based capital requirements. The managed care organization rules, if adopted by Indiana and New Jersey, may increase the

minimum capital required for these subsidiaries. We continue to monitor these requirements and do not expect that they will have a material impact on earnings or cash flows.

Recent Accounting Pronouncements

In July 2001, SFAS No. 142, "Goodwill and Other Intangible Assets," was issued which requires that goodwill and intangible assets with indefinite useful lives no longer be amortized, but instead tested at least annually for impairment. We have adopted SFAS No. 142 effective January 1, 2002, and goodwill amortization was discontinued. For the year ended December 31, 2001, this adjustment would have added $471,000 in net earnings, or $0.06 per diluted share and $0.34 per basic share. For the year ended December 31, 2000, this adjustment would have added $224,000 in net earnings, or $0.03 per diluted share and $0.25 per basic share. Goodwill is reviewed at least annually for impairment. In addition, we will perform an impairment analysis of intangible assets more frequently based on other factors. Such factors would include, but would not be limited to, significant changes in membership, state funding, Medicaid contracts and provider networks and contracts. We did not recognize any impairment losses for the periods presented.

In August 2001, SFAS No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets," was issued. SFAS No. 144 provides updated guidance concerning the recognition and measurement of an impairment loss for certain types of long-lived assets. It also expands the scope of a discontinued operation to include a component of an entity. SFAS No. 144 is effective for financial statements issued for fiscal years beginning after December 15, 2001, and interim periods within those years. The adoption of the provisions of SFAS No. 144 did not have a material impact on our results of operations, financial position or cash flows.

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

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

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

In November 2002, FIN No. 45, "Guarantor's Accounting and Disclosure Requirements for Guarantees, Including Indirect Guarantees of Indebtedness of Others an Interpretation of SFAS No. 5, 57, and 107 and Rescission of FASB Interpretation No. 34," was issued. FIN 45 clarifies the

requirements of SFAS No. 5, "Accounting for Contingencies," relating to a guarantor's accounting for, and disclosure of, the issuance of certain types of guarantees.

We have adopted the disclosure requirements of FIN 45 as required for fiscal years ending after December 15, 2002 and will adopt the provisions for initial recognition and measurement for all guarantees issued or modified after December 31, 2002. The adoption of FIN 45 related to initial recognition and measurement of guarantees is not expected to have a significant impact on our net income or equity. We have completed an inventory of potential contingencies and noted one potential guarantee that would require the following disclosure in our financial statement footnotes per FIN 45:

"Within the Company's Medicaid contract with the state of Wisconsin, the Company is required to pay a fee if its contracted physicians do not provide an adequate number of healthy examinations to certain member groups. This agreement constitutes a performance guarantee. At the end of each fiscal year, the Company performs an analysis to estimate the amount owed to the state of Wisconsin, if any, under the performance guarantees. The state of Wisconsin, however, does not calculate or request payment for the amount owed until at least thirteen months subsequent to each year end. As such, the Company has recorded a current payable for any portions owed within one year and a long-term liability for portions owed for a period greater than one year from the balance sheet date. As of December 31, 2002 and 2001, the Company recorded $2.0 million and $829,000, respectively, of accounts payable and other accrued expenses for the current portions of the fees owed and $1.0 million at both year ends of other long-term liabilities for the long-term portions."

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

Forward-Looking Statements

This report contains forward-looking statements that relate to future events or our future financial performance. We have attempted to identify these statements by terminology including "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "goal," "may," "will," "should," "can," "continue" or the negative of these terms or other comparable terminology. These statements include statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions and investments, and the adequacy of our available cash resources. These statements may be found in the section of this report entitled "Management's Discussion and Analysis of Financial Condition and Results of Operations." 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.

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

Factors That May Affect Future Results

Risks Related to Being a Regulated Entity

Reductions in Medicaid Funding Could Substantially Reduce Our Profitability.

Nearly all of our revenues come from Medicaid 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 premium rates may be affected by continued government efforts to contain medical costs and may further be affected by state and federal budgetary constraints. Changes to Medicaid programs could reduce the number of persons enrolled or eligible, reduce the amount of reimbursement or payment levels, or increase our administrative or healthcare costs under those programs. States periodically consider reducing or reallocating the amount of money they spend for Medicaid. We believe that additional reductions in Medicaid payments could substantially reduce our profitability. Further, our contracts with the states are subject to cancellation by the state immediately or after a short notice period in the event of unavailability of state funds.

If Our Medicaid and SCHIP Contracts Are Terminated or Are Not Renewed, Our Business Will Suffer.

We provide managed care programs and select services to individuals receiving benefits under Medicaid, including SSI and SCHIP. We provide these healthcare services under contracts with regulatory entities in the areas in which we operate. The contracts expire on various dates between June 30, 2003 and December 31, 2003. Our contracts with the states of Indiana and Wisconsin accounted for 73% of our revenues for the year ended December 31, 2002. Our contracts may be terminated if we fail to perform up to the standards set by state regulatory agencies. In addition, the Indiana contract under which we operate can be terminated by the state without cause. Our contracts are generally intended to run for two years and may be extended for one or two additional years if the state or its contractor elects to do so. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. If any of our contracts are terminated, not renewed, or renewed on less favorable terms, our business will suffer, and our operating results may be materially affected.

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

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

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

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

Regulations May Decrease the Profitability of Our Health Plans.

Our Texas plans are required to pay a rebate to the state in the event profits exceed established levels. To date no rebates have been required. This regulatory requirement, changes in this requirement or the adoption of similar requirements by our other regulators may limit our ability to increase our overall profits as a percentage of revenues. The State of Texas has implemented and is enforcing a penalty provision for failure to pay claims in a timely manner. Failure to meet this requirement can result in financial fines and penalties. In addition, states may attempt to reduce their contract premium rates if regulators perceive our medical loss ratio as too low. Any of these regulatory actions could harm our operating results.

Also, on January 18, 2002, the federal government's Centers for Medicare and Medicaid Services, or CMS, published a final rule that removed an exception contained in the federal Medicaid reimbursement regulations permitting states to reimburse non-state government-owned or operated hospitals for inpatient and outpatient hospital services at amounts up to 150 percent of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicaid payment principles. This development in federal law could decrease the profitability of our health plans.

Failure to Comply with Government Regulations Could Subject Us to Civil and Criminal Penalties.

Federal and state governments have enacted fraud and abuse laws and other laws to protect patients' privacy and access to healthcare. Violation of these and other laws or regulations governing our operations or the operations of our providers could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide services, the suspension or revocation of our licenses or our exclusion from participating in the Medicaid, SSI and SCHIP programs. Because of these potential sanctions, we seek to monitor our compliance and that of our providers with federal and state fraud and abuse and other healthcare laws on an ongoing basis. These penalties or exclusions, were they to occur as the result of our actions or omissions, or our inability to monitor the compliance of our providers, would negatively impact our ability to operate our business. For example, failure to pay our providers promptly could result in the imposition of fines and other penalties. In some states, we may be subject to regulation by more than one governmental authority, which may impose overlapping or inconsistent regulations.

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

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

In August 2000, the Department of Health and Human Services, or HHS, issued a new regulation under HIPAA requiring the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. We are required to comply with the new regulation by October 2003, and Texas has indicated that it may impose an earlier compliance deadline. In August 1998, HHS proposed a regulation that would require healthcare participants to implement organizational and technical practices to protect the security of electronically maintained or transmitted health-related information. In December 2000, HHS issued a new regulation mandating heightened privacy and confidentiality protections under HIPAA that became effective on April 14, 2001. Compliance with this regulation will be required by April 14, 2003.

The Bush Administration's issuance of new regulations and its review of existing regulations, the states' ability to promulgate stricter rules, and uncertainty regarding many aspects of the regulations may make compliance with the relatively new regulatory landscape difficult. Our existing programs and systems may not enable us to comply in all respects with these new regulations. In order to comply with the regulatory requirements, we will be required to employ additional or different programs and systems, the costs of which are not expected to exceed $500,000 in 2003. Further, compliance with these regulations would require changes to many of the procedures we currently use to conduct our business, which may lead to additional costs that we have not yet identified. We do not know whether, or the extent to which, we will be able to recover our costs of complying with these new regulations from the states. The new regulations and the related compliance costs could have a material adverse effect on our business.

Changes in Healthcare Law 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. These changes could reduce the number of persons enrolled or eligible for Medicaid and reduce the reimbursement or payment levels for medical services. More generally, we are unable to predict whether new laws or proposals will favor or hinder the growth of managed healthcare.

We cannot predict the outcome of these legislative or regulatory proposals or the effect that they will have on us. Legislation or regulations that require us to change our current manner of operation, provide additional benefits or change our contract arrangements may seriously harm our operations and financial results.

Changes in Federal Funding Mechanisms May Reduce Our Profitability.

In February 2003, the Bush Administration proposed a major long-term change in the way Medicaid and SCHIP are funded. The proposal, if adopted, would allow states to elect to receive combined Medicaid-SCHIP "allotments" for acute

and long-term 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, or if so, how it may change from the initial proposal. Accordingly, it is unknown whether or how many states might elect to participate or how their participation may affect the net amount of funding available for Medicaid and SCHIP programs. If such a proposal is adopted and decreases the number of persons enrolled in Medicaid or SCHIP in the states in which we operate or reduces the volume of healthcare services provided, our growth, operations and financial performance could be adversely affected.

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

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

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

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

Risks Related to Our Business

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

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

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

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

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

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

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

Historically, the acquisition of Medicaid businesses, contract rights and related assets of other health plans both in our existing service areas and in new markets, has accounted for a significant amount of our growth. For example, our acquisition of 80% of the equity of UHP on December 1, 2002, accounted for 30.3% of the increase in our membership for the year ended December 31, 2002 compared to 2001. Many of the other potential purchasers of Medicaid assets have greater financial resources than we have. In addition, many of the sellers are interested either in (1) selling, along with their Medicaid assets, other assets in which we do not have an interest or (2) 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 may 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. We cannot assure you that we would be able to comply with these regulatory requirements for an acquisition in a timely manner, or at all. In deciding whether to approve a proposed acquisition, state regulators may consider a number of factors outside our control, including giving preference to competing offers made by locally owned entities or by not-for-profit entities. Furthermore, our credit facility may prohibit some acquisitions without the consent of our bank lender.

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

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

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

Failure to Achieve Timely Profitability in Any Business Would Negatively Affect Our Results of Operations.

Start-up costs associated with a new business can be substantial. For example, in order to obtain a certificate of authority in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to obtain a state contract and process claims. If we were unsuccessful in obtaining the necessary license, winning the bid to provide service or attracting members in numbers sufficient to cover our costs, any new business of ours would fail. We also could be obligated by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or recover start-up costs. In addition, we may not be able to effectively commercialize any new programs or services we seek to market to third parties. The expenses associated with starting up a new business could have a significant impact on our results of operations if we are unable to achieve profitable operations in a timely fashion.

We Derive All of Our Revenues from Operations in Four States, and Our Operating Results Would Be Materially Affected by a Decrease in Revenues or Profitability in Any One of Those States.

Operations in Wisconsin, Indiana, Texas and New Jersey account for all of our revenues. If we were unable to continue to operate in each of those states or if our current operations in any portion of one of those states were significantly curtailed, our revenues would decrease materially. In the first half of 2001, our membership in Indiana declined by approximately 46,000 due to a subcontracting provider organization terminating a percent-of-premium arrangement. In 2000, we reduced our service area in Wisconsin from 36 to 18 counties. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly, depending on legislative actions, economic conditions and similar factors in those states. Our inability to continue to operate in any of the states in which we operate would harm our business.

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

We compete for members principally on the basis of size and quality of provider network, benefits provided and quality

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

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

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

If We Are Unable to Maintain Satisfactory Relationships With Our Provider Networks, Our Profitability Will Be Harmed.

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

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

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

We May Be Unable to Attract and Retain Key Personnel.

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our Medicaid managed care business. If we lose one or more members of our senior management team, including our chief executive officer, Michael F. Neidorff, who has been instrumental in developing our mission and forging our business relationships, our business and operating results could be harmed. We do not have an employment agreement with Mr. Neidorff, and we cannot assure you that we will be able to retain his services. Our ability to replace any departed members of our senior management or other key employees may be difficult and may take an extended period of time because of the limited number of individuals in the Medicaid managed care industry with the breadth of skills and experience required to operate and expand successfully a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel.

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

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

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

Our providers and employees involved in medical care decisions may be subject to medical malpractice claims. Some states, including Texas, have adopted legislation that permits managed care organizations to be held liable for negligent

treatment decisions or benefits coverage determinations. In addition, plaintiffs in cases pending in federal courts are seeking to hold managed care organizations liable for denying medically necessary treatment and denying or delaying payments for services performed. Claims of this nature, if successful, could result in substantial damage awards against us and our providers that could exceed the limits of any applicable insurance coverage. Therefore, successful malpractice or tort claims asserted against us, our providers or our employees could adversely affect our financial condition and profitability. Even if any claims brought against us are unsuccessful or without merit, they would still be time-consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively.

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

Less favorable economic conditions may cause our membership to increase as more people become eligible to receive Medicaid benefits. During such economic downturns, however, state and federal budgets could decrease, causing states to attempt to cut healthcare programs, benefits and rates. In particular, we cannot predict the impact of acts of terrorism or related military action on federal or state funding of healthcare programs or on the size of the Medicaid-eligible population. If federal funding were decreased or unchanged while our membership was increasing, our results of operations would suffer.

Growth in the Number of Medicaid-Eligible Persons May Be Countercyclical, Which Could Cause Our Operating Results to Suffer When General Economic Conditions Are Improving.

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

We Intend to Expand Primarily into Markets Where Medicaid Recipients Are Required to Enroll in Managed Care Plans.

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

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

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

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

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

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

QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Investments

As of December 31, 2002, we had short-term investments of $9.6 million and long-term investments of $95.4 million, including restricted deposits of $15.8 million. The short-term investments consist of highly liquid securities with maturities between three and 12 months. The long-term investments consist of municipal bonds, U.S. government-backed agencies and U.S. Treasury investments, and have original maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. These investments are classified as long-term regardless of the contractual maturity date due to the nature of the state's requirements. These investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold these short-term investments to maturity, and as a result, we would not expect the value of these investments to decline significantly as a result of a sudden change in market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2002, the fair value of our fixed income investments would decrease by approximately $2.6 million. Similarly, a 1% decrease in market interest rates at December 31, 2002 would result in an increase of the fair value of our investments of approximately $2.6 million. Declines in interest rates over time will reduce our investment income.

Inflation

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

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

Compliance Costs

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

CONSOLIDATED BALANCE SHEETS

	December 31,	
	2002	2001
	(In thousands, except share data)	
Assets:		
Current assets:		
Cash and cash equivalents	$ 59,656	$ 88,867
Premium and related receivables, net of allowances of $219 and $3,879, respectively	16,773	7,032
Short-term investments, at fair value (amortized cost $9,687 and $1,166, respectively)	9,571	1,169
Deferred income taxes	2,846	2,515
Other current assets	4,243	2,464
Total current assets	93,089	102,047
Long-term investments, at fair value (amortized cost $78,025 and $20,923, respectively)	79,666	21,119
Restricted deposits, at fair value (amortized cost $15,561 and $1,204, respectively)	15,762	1,220
Property and equipment, net	6,295	3,796
Other assets	4,348	—
Intangible assets, net	10,695	2,396
Deferred income taxes	472	788
Total assets	$210,327	$131,366
Liabilities and stockholders' equity:		
Current liabilities:		
Medical claims liabilities	$ 91,181	$ 59,565
Accounts payable and accrued expenses	10,748	6,712
Total current liabilities	101,929	66,277
Other liabilities	5,334	1,000
Total liabilities	107,263	67,277
Minority interest	881	—
Stockholders' equity:		
Common stock, $.001 par value; authorized 40,000,000 shares; 10,829,099 and 10,085,112 shares issued and outstanding	11	10
Additional paid-in capital	72,377	60,857
Accumulated other comprehensive income:		
Net unrealized gain on investments, net of tax	1,087	135
Retained earnings	28,708	3,087
Total stockholders' equity	102,183	64,089
Total liabilities and stockholders' equity	$210,327	$131,366

The accompanying notes are an integral part of these balance sheets.

CONSOLIDATED STATEMENTS OF EARNINGS

	Year Ended December 31,		
	2002	2001	2000
	(In thousands, except share data)		
Revenues:			
Premiums	$461,030	$326,184	$216,414
Administrative services fees	457	385	4,936
Total revenues	461,487	326,569	221,350
Expenses:			
Medical services costs	379,468	270,151	182,495
General and administrative expenses	50,413	37,946	32,335
Total operating expenses	429,881	308,097	214,830
Earnings from operations	31,606	18,472	6,520
Other income (expense):			
Investment and other income, net	9,575	3,916	1,784
Interest expense	(45)	(362)	(611)
Equity in losses from joint ventures	—	—	(508)
Earnings from operations before income taxes	41,136	22,026	7,185
Income tax expense (benefit)	15,631	9,131	(543)
Minority interest	116	—	—
Net earnings	25,621	12,895	7,728
Accretion of redeemable preferred stock	—	(467)	(492)
Net earnings attributable to common stockholders	$ 25,621	$ 12,428	$ 7,236
Earnings per common share, basic:			
Net earnings per common share	$ 2.45	$ 8.97	$ 8.03
Earnings per common share, diluted:			
Net earnings per common share	$ 2.20	$ 1.61	$ 1.13
Shares used in computing per share amounts:			
Basic	10,477,360	1,385,399	901,526
Diluted	11,644,077	8,019,497	6,819,595

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

For the Years Ended December 31, 2002, 2001 and 2000 (In thousands, except share data)

	Preferred Stock					
	Series A Shares	Amt	Series B Shares	Amt	Series C Shares	Amt
Balance, December 31, 1999	733,850	$ 123	864,640	$ 144	557,850	$ 93
Net earnings	—	—	—	—	—	—
Net unrealized investment gains, net of $136 tax	—	—	—	—	—	—
Comprehensive earnings						
Series D preferred stock accretion	—	—	—	—	—	—
Balance, December 31, 2000	733,850	$ 123	864,640	$ 144	557,850	$ 93
Net earnings	—	—	—	—	—	—
Net unrealized investment gains, net of $32 tax	—	—	—	—	—	—
Comprehensive earnings						
Issuance of common stock upon exercise of options	—	—	—	—	—	—
Purchase of stock	—	—	—	—	—	—
Stock compensation expense	—	—	—	—	—	—
Series D preferred stock accretion	—	—	—	—	—	—
Exercise of warrants to purchase common stock	—	—	—	—	—	—
Conversion of Series A, B, C and D preferred stock to common stock	(733,850)	(123)	(864,640)	(144)	(557,850)	(93)
Conversion of Series A and B common stock to $.001 par value common stock	—	—	—	—	—	—
Issuance of 3,250,000 shares of common stock, net	—	—	—	—	—	—
Issuance of common stock for purchase of joint venture interest	—	—	—	—	—	—
Balance, December 31, 2001	—	$ —	—	$ —	—	$ —
Net earnings	—	—	—	—	—	—
Net unrealized investment gains, net of $559 tax	—	—	—	—	—	—
Comprehensive earnings						
Issuance of common stock in relation to stock options and employee stock purchase plan	—	—	—	—	—	—
Issuance of 470,495 shares of common stock, net	—	—	—	—	—	—
Stock compensation expense	—	—	—	—	—	—
Tax benefit of disqualifying dispositions	—	—	—	—	—	—
Balance, December 31, 2002	—	$ —	—	$ —	—	$ —

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

For the Years Ended December 31, 2002, 2001 and 2000 / In thousands, except share data (continued)

Common Stock				Common Stock					
Series A Shares	Amt	Series B Shares	Amt	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Net Unrealized Gain (Loss) on Investments	Retained Earnings (Deficit)	Total
277,247	$ 1	624,279	$ 2	—	$ —	$ 7	$ (216)	$(16,521)	$(16,367)
—	—	—	—	—	—	—	—	7,728	7,728
—	—	—	—	—	—	—	297		297
									8,025
—	—	—	—	—	—	—	—	(492)	(492)
277,247	$ 1	624,279	$ 2	—	$ —	$ 7	$ 81	$ (9,285)	$ (8,834)
—	—	—	—	—	—	—	—	12,895	12,895
—	—	—	—	—	—	—	54	—	54
									12,949
19,100	—	—	—	—	—	32	—	—	32
(11,000)	—	—	—	—	—	(30)	—	(56)	(86)
—	—	—	—	—	—	6	—	—	6
—	—	—	—	—	—	—	—	(467)	(467)
—	—	46,003	—	—	—	18	—	—	18
—	—	—	—	5,872,340	6	19,683	—	—	19,329
(285,347)	(1)	(670,282)	(2)	955,629	1	2	—	—	—
—	—	—	—	3,250,000	3	41,039	—	—	41,042
—	—	—	—	7,143	—	100	—	—	100
—	$ —	—	$ —	10,085,112	$10	$60,857	$ 135	$ 3,087	$ 64,089
—	—	—	—	—	—	—	—	25,621	25,621
—	—	—	—	—	—	—	952	—	952
									26,573
—	—	—	—	273,492	—	491	—	—	491
—	—	—	—	470,495	1	10,317	—	—	10,318
—	—	—	—	—	—	270	—	—	270
—	—	—	—	—	—	442	—	—	442
—	$ —	—	$ —	10,829,099	$11	$72,377	$1,087	$ 28,708	$102,183

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2002	2001	2000
	(In thousands)		
Cash flows from operating activities:			
Net earnings	$ 25,621	$ 12,895	$ 7,728
Adjustments to reconcile net earnings to net cash provided by operating activities—			
Depreciation and amortization	2,565	1,847	1,034
Stock compensation expense	270	6	—
Minority interest	(116)	—	—
(Gain) loss on sale of investments	(649)	(390)	40
Equity in losses from joint ventures	—	—	508
Changes in assets and liabilities—			
(Increase) decrease in premium and related receivables	(2,449)	9,406	(4,087)
(Increase) decrease in other current assets	(1,463)	(238)	684
Increase in deferred income taxes	(574)	(37)	(584)
Decrease in other assets	857	—	—
Increase in medical claims liabilities	15,386	8,686	8,466
Decrease in unearned premiums	(827)	—	(3,601)
Increase (decrease) in accounts payable and accrued expenses	1,910	(1,987)	3,270
Decrease in other liabilities	(872)	—	—
Net cash provided by operating activities	39,659	30,188	13,458
Cash flows from investing activities:			
Purchase of property and equipment	(3,918)	(3,635)	(642)
Purchase of investments	(192,371)	(25,481)	(20,260)
Sales and maturities of investments	127,706	25,037	7,382
Contract acquisitions	(595)	(1,250)	—
Investments in subsidiaries	(10,501)	7,995	(1,097)
Net cash (used in) provided by investing activities	(79,679)	2,666	(14,617)
Cash flows from financing activities:			
Payment of note payable	—	—	(2,350)
Payment of subordinated debt	—	(4,000)	—
Proceeds from exercise of stock options	491	32	—
Net proceeds from issuance of common stock	10,318	41,042	—
Purchase of stock	—	(102)	—
Proceeds from exercise of warrants	—	18	—
Net cash provided by (used in) financing activities	10,809	36,990	(2,350)
Net (decrease) increase in cash and cash equivalents	(29,211)	69,844	(3,509)
Cash and cash equivalents, beginning of period	88,867	19,023	22,532
Cash and cash equivalents, end of period	$ 59,656	$ 88,867	$ 19,023
Interest paid	$ 28	$ 920	$ 531
Income taxes paid	$ 16,433	$ 9,460	$ 310

The accompanying notes are an integral part of these statements.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Dollars in thousands, except share data

1. Organization and Operations

Centene Corporation (Centene or the Company) provides managed care programs and related services to individuals receiving benefits under Medicaid, including Supplemental Security Income (SSI), and State Children's Health Insurance Program (SCHIP). Centene operates under its own state licenses in Wisconsin, Indiana, Texas and New Jersey, and contracts with other managed care organizations to provide risk and nonrisk management services.

Centene's managed care organization (MCO) subsidiaries include Managed Health Services Insurance Corp. (MHSIC), a wholly owned Wisconsin corporation; Coordinated Care Corporation Indiana, Inc. (CCCI), a wholly owned Indiana corporation; Superior HealthPlan, Inc. (Superior), a wholly owned Texas corporation (39% before January 1, 2001); and University Health Plans, Inc. (UHP), an 80% owned New Jersey corporation.

Centene's other subsidiaries include Bankers Reserve Life Insurance Company of Wisconsin (Bankers Reserve), a wholly owned Wisconsin corporation that the Company purchased on March 14, 2002, and NurseWise, Inc., a wholly owned Delaware corporation that was incorporated in August of 2002.

The Company is currently operated as one business segment, which includes both its underwritten and administrative only services provided to individuals receiving benefits under Medicaid, including SSI, and SCHIP.

2. Initial Public Offering and Follow-on

On December 13, 2001, the Company completed an initial public offering (IPO) of 3,250,000 shares of its common stock at $14.00 per share. The net proceeds, after paying the underwriting discount and expenses associated with the offering, were $41,000. In conjunction with the IPO all outstanding shares of preferred stock were converted into shares of common stock in accordance with their terms.

On May 22, 2002, the Company closed a follow-on public offering of 5,000,000 shares of common stock at $24.75 per share. Of the 5,000,000 shares, 4,600,000 shares were offered by selling stockholders and 400,000 by the Company. On June 5, 2002, the underwriters of the follow-on public offering exercised their over-allotment option to purchase 679,505 additional shares from selling stockholders and 70,495 additional shares from the Company. Centene received net proceeds of $10,300 from the two closings of the follow-on offering.

3. Summary of Significant Accounting Policies

The accompanying consolidated financial statements include the accounts of Centene Corporation and all majority owned subsidiaries. All material intercompany balances and transactions have been eliminated.

Cash and Cash Equivalents

Investments with original maturities of three months or less at the date of acquisition are considered to be cash equivalents. Cash equivalents consist of commercial paper, money market funds and bank savings accounts.

Investments

Short-term investments include securities with original maturities between three months and one year. Long-term investments include securities with original maturities greater than one year.

Short-term and long-term investments are classified as available for sale and are carried at fair value based on quoted market prices. Unrealized gains and losses on investments available for sale are excluded from earnings and reported as a separate component of stockholders' equity, net of income tax effects. Premiums and discounts are amortized or accreted over the life of the related security using the effective interest method. The Company monitors the difference between the cost and fair value of investments. Investments that experience a decline in value that is judged to be other than temporary are written down to fair value and a realized loss is recorded in investment and other income. To calculate realized gains and losses on the sale of investments, the Company uses the specific amortized cost of each investment sold. Realized gains and losses are recorded in investment and other income.

As part of the Company's acquisition of UHP, certain call and put option rights were received and granted (see Note 21). The Company is in the process of obtaining third-party valuations related to the fair value of the call and put options, which may result in an increase or decrease in the portion of the purchase price allocated to goodwill. The fair value of the call option, once determined, will be evaluated for impairment. To the extent that impairment would be determined, adjustments would be recorded as a charge to investment income. The fair value of the put option, once determined, will be evaluated on a quarterly basis, with adjustments in the fair values being recorded as a charge or credit to investment income.

The Company did not own any unaffiliated equity investments as of December 31, 2002. During 2002 and 2001, the Company maintained an equity investment in an unaffiliated reinsurance company. The estimated fair value of this investment, which approximated the original cost, was not significant and was included within other long-term investments as of December 31, 2001. This investment was sold in July 2002.

Restricted Deposits

Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. These investments are classified as long-term, regardless of the contractual maturity date due to the nature of the states' requirements.

Under the State of New Jersey Department of Banking and Insurance (DOBI) regulations, UHP is required to maintain certain insolvency deposits in a custodial account for the protection of enrollees. UHP is entitled to receive interest income on these deposits; however, the principal may not be withdrawn without the written consent of the Commissioner of the DOBI. The minimum deposit requirement is calculated on December 31 of each year and must be funded by June 30 of the following year. The restricted amounts are invested in money market funds. The minimum deposit requirement based on the December 31, 2002 calculation is $15,422. The total unfunded balance at December 31, 2002 is $3,237. The Company intends to fund the minimum deposit requirement from unrestricted cash and cash equivalents.

All other restricted deposit requirements were fully funded on December 31, 2002.

Property and Equipment

Furniture, equipment and leasehold improvements are carried at cost less accumulated depreciation. Depreciation for furniture and equipment, other than computer equipment, is calculated based on the estimated useful lives of the assets ranging between five and seven years. Depreciation for computer equipment is calculated using the straight-line method based on a three-year life. Software is stated at cost and is amortized over its estimated useful life of three years using the straight-line method. Depreciation for leasehold improvements is calculated using the straight-line method based on the shorter of the estimated useful lives of the asset or the term of the respective leases, ranging between three and ten years.

Intangible Assets

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

Effective January 1, 2002, the Company ceased to amortize goodwill in accordance with SFAS No. 142, "Goodwill and Other Intangible Assets." Goodwill is reviewed at least annually for impairment. In addition, the Company will perform an impairment analysis of intangible assets more frequently based on other factors. Such factors would include, but are not limited to, significant changes in membership, state funding, medical contracts and provider networks and contracts. An impairment loss is recognized if the carrying value of goodwill exceeds the implied fair value. The Company did not recognize any impairment losses for the periods presented.

Medical Claims Liabilities

Medical services costs include claims paid, claims adjudicated but not yet paid, estimates for claims received but not yet adjudicated, estimates for claims incurred but not yet received and estimates for the costs necessary to process unpaid claims.

The estimates of medical claims liabilities are developed using standard actuarial methods based upon historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors including product changes. These estimates are continually reviewed and adjustments, if necessary, are reflected in the period known.

Accounts Payable and Accrued Expenses

Accounts payable and accrued expenses include accrued wages and related payroll taxes, federal and state tax payables and payments owed to vendors for services performed in the normal course of business.

Other Assets and Liabilities

Other assets and liabilities consist principally of Separate Account assets of $4,298 and related Separate Account liabilities of $4,298 as of December 31, 2002 (see Note 24). In addition, other liabilities include certain payments due to various states related to minimum performance guarantees.

Premium Revenue and Related Receivables
The majority of the Company's premium revenue is received monthly based on fixed rates per member as determined by the state contracts. Some contracts allow for additional premium related to certain supplemental services provided such as maternity deliveries. The revenue is recognized as earned over the covered period of services. Premiums collected in advance are recorded as unearned premiums. Premiums due to the Company are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and management's judgement on the collectibility of these accounts.

As the Company generally receives premiums during the month in which services are provided, the allowance is typically not significant in comparison to total premium revenue. From 1998 to 2000, however, Centene provided Medicaid services in certain regions of Indiana as a subcontractor with Maxicare Indiana, Inc. In June 2001, the Insurance Commissioner of the Indiana Department of Insurance declared Maxicare insolvent and ordered Maxicare into liquidation. As a result, Centene recorded an allowance for uncollectible receivables in the amount of $2,700 to fully reserve for all receivables from Maxicare as of December 31, 2001. In 2002, subsequent to a release and settlement agreement with Maxicare and the Indiana Insurance Commissioner which requires no payment by either Maxicare or Centene, Centene wrote off the entire balance of the receivable from Maxicare as uncollectible and reduced the related allowance for doubtful accounts. There are no contractual allowances related to Centene's premium revenue.

Significant Customers
Centene receives the majority of its revenues under contracts or subcontracts with state Medicaid managed care programs. The contracts, which expire on various dates between June 30, 2003 and December 31, 2003, are expected to be renewed. Our contracts with the states of Wisconsin, Indiana and Texas accounted for 44%, 30% and 24%, respectively, of the Company's revenues for the year ended December 31, 2002.

Reinsurance
Centene's MCO subsidiaries have purchased reinsurance from third parties to cover eligible healthcare services. The current reinsurance agreements generally cover 90% of inpatient healthcare expenses in excess of annual deductibles of $75 to $150 per member, up to a lifetime maximum of $2,000. The subsidiaries are responsible for inpatient charges in excess of an average daily per diem.

Reinsurance recoveries were approximately $1,542, $3,958 and $1,454 in 2002, 2001 and 2000, respectively. Reinsurance expenses were approximately $3,981, $10,252 and $3,391 in 2002, 2001 and 2000, respectively. Reinsurance recoveries, net of expenses, are included in medical services costs.

Other Income (Expense)
Other income (expense) consists principally of investment and other income and interest expense. Investment income is derived from the Company's cash, cash equivalents and investments. For the year ended December 31, 2002, investment income included a $5,100 one-time dividend from a captive insurance company in which the Company maintained an investment. For the year ended December 31, 2000, other income included equity in losses from a joint venture. Interest expense for the year ended December 31, 2002, included commitment fees paid to a bank in conjunction with the Company's revolving line of credit. Interest expense for the years ended December 31, 2001 and 2000, reflected interest paid on the Company's subordinated notes, which were paid in full in December 2001.

Income Taxes
Centene recognizes deferred tax assets and liabilities for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date of the tax rate change.

Estimates
The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Reclassifications
Certain 2001 amounts in the consolidated financial statements have been reclassified to conform to the 2002 presentation. These reclassifications have no effect on net earnings or shareholders' equity as previously reported.

Dollars in thousands, except share data

Recent Accounting Pronouncements

In July 2001, Statement of Financial Accounting Standards No. 142, "Goodwill and Other Intangible Assets," was issued which requires that goodwill and intangible assets with indefinite useful lives no longer be amortized, but instead tested at least annually for impairment. The Company has adopted SFAS No. 142 effective January 1, 2002 and goodwill amortization was discontinued. Goodwill is reviewed at least annually for impairment. In addition, the Company will perform an impairment analysis of intangible assets more frequently based on other factors. Such factors would include, but are not limited to, significant changes in membership, state funding, medical contracts and provider networks and contracts. The Company did not recognize any impairment losses for the periods presented.

The effect of this adjustment on net earnings as well as basic and diluted earnings per share for the years ended December 31, 2001 and 2000, follows:

	2001	2000
Net earnings, as reported	$12,428	$7,236
Goodwill amortization	471	224
Adjusted net earnings	$12,899	$7,460
Earnings Per Common Share, Basic:		
Net earnings, as reported	$ 8.97	$ 8.03
Goodwill amortization	0.34	0.25
Adjusted net earnings	$ 9.31	$ 8.28
Earnings Per Common Share, Diluted:		
Net earnings, as reported	$ 1.61	$ 1.13
Goodwill amortization	0.06	0.03
Adjusted net earnings	$ 1.67	$ 1.16

In August 2001, SFAS No. 144, "Accounting for the Impairment or Disposal of Long-Lived Assets," was issued. SFAS No. 144 provides updated guidance concerning the recognition and measurement of an impairment loss for certain types of long-lived assets. It also expands the scope of a discontinued operation to include a component of an entity. SFAS No. 144 is effective for financial statements issued for fiscal years beginning after December 15, 2001, and interim periods within those years. The adoption of the provisions of SFAS No. 144 did not have a material impact on the Company's results of operations, financial position or cash flows.

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

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

In December 2002, SFAS No. 148, "Accounting for Stock-Based Compensation—Transition and Disclosure," was issued. This Statement amends FASB Statement No. 123, "Accounting for Stock-Based Compensation," to provide alternative methods of transition for an entity that voluntarily changes to the fair value based method of accounting for stock-based employee compensation. In addition, this Statement amends the disclosure requirements of SFAS No. 123 and APB Opinion No. 28, "Interim Financial Reporting," to require prominent disclosures in both annual and interim financial statements about the method of accounting for stock-based employee compensation and the effect of the method used on reported results. SFAS No. 148 is

effective for fiscal years ending after December 15, 2002 and for interim periods beginning after December 15, 2002. The adoption of the provisions of SFAS No. 148 did not have a material impact on the Company's results of operations, financial position or cash flows.

In November 2002, FIN No. 45, "Guarantor's Accounting and Disclosure Requirements for Guarantees, Including Indirect Guarantees of Indebtedness of Others, an Interpretation of SFAS No. 5, 57, and 107 and Rescission of FASB Interpretation No. 34," was issued. FIN 45 clarifies the requirements of SFAS No. 5, "Accounting for Contingencies," relating to a guarantor's accounting for, and disclosure of, the issuance of certain types of guarantees.

Centene has adopted the disclosure requirements of FIN 45 as required for fiscal years ending after December 15, 2002 and will adopt the provisions for initial recognition and measurement for all guarantees issued or modified after December 31, 2002. The adoption of FIN 45 related to initial recognition and measurement of guarantees is not expected have a significant impact on the net income or equity of the Company. The Company has completed an inventory of potential contingencies and noted one potential guarantee that would require the following disclosure per FIN 45:

"Within the Company's Medicaid contract with the state of Wisconsin, the Company is required to pay a fee if its contracted physicians do not provide an adequate number of healthy examinations to certain member groups. This agreement constitutes a performance guarantee. At the end of each fiscal year, the Company performs an analysis to estimate the amount owed to the state of Wisconsin, if any, under the performance guarantees. The state of Wisconsin, however, does not calculate or request payment for the amount owed until at least thirteen months subsequent to each year end. As such, the Company has recorded a current payable for any portions owed within one year and a long-term liability for portions owed for a period greater than one year from the balance sheet date. As of December 31, 2002 and 2001, the Company recorded $2,004 and $829, respectively, of accounts payable and other accrued expenses for the current portions of the fees owed and $1,036 and $1,000, respectively, of other long-term liabilities for the long-term portions."

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

4. Short-Term and Long-Term Investments and Restricted Deposits

Short-term and long-term investments and restricted deposits available for sale by investment type consist of the following:

	December 31, 2002			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Market Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 2,797	$ 204	$ (3)	$ 2,998
Commercial paper	13,278	—	—	13,278
State/municipal securities and other	87,198	1,669	(144)	88,723
Total	$103,273	$1,873	$(147)	$104,999

	December 31, 2001			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Market Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 17,998	$ 216	$ (3)	$ 18,211
Commercial paper	462	3	—	465
State/municipal securities and other	4,833	8	(9)	4,832
Total	$ 23,293	$ 227	$ (12)	$ 23,508

Dollars in thousands, except share data

The contractual maturity of short-term and long-term investments and restricted deposits as of December 31, 2002, are as follows:

	Investments		Restricted Deposits	
	Amortized Cost	Estimated Market Value	Amortized Cost	Estimated Market Value
One year or less	$ 9,687	$ 9,571	$12,764	$12,764
One year through five years	34,065	34,637	1,882	1,985
Five years through ten years	35,544	36,611	915	1,013
After ten years	8,416	8,418	—	—
Total	$87,712	$89,237	$15,561	$15,762

Actual maturities may differ from contractual maturities due to call or prepayment options.

The Company recorded realized gains and losses on the sale of investments for the years ended December 31 as follows:

	2002	2001	2000
Gross realized gains	$698	$424	$ 57
Gross realized losses	(49)	(34)	(97)
Net realized gains/(losses)	$649	$390	$(40)

Various state statutes require MCOs to deposit or pledge minimum amounts of investments to state agencies. Securities with an amortized cost of $15,561 and $1,204 were deposited or pledged to state agencies by Centene's MCO subsidiaries at December 31, 2002 and 2001, respectively. These investments are classified as long-term restricted deposits in the consolidated financial statements due to the nature of the states' requirements.

5. Property and Equipment

Property and equipment consist of the following as of December 31:

	2002	2001
Furniture and office equipment	$ 6,461	$ 4,349
Computer software	4,724	2,423
Leasehold improvements	1,286	878
Building	434	—
Land	151	10
	13,056	7,660
Less—accumulated depreciation	(6,761)	(3,864)
Property and equipment, net	$ 6,295	$ 3,796

Depreciation expense for the years ended December 31, 2002, 2001 and 2000 was $1,887, $1,199, and $810, respectively.

6. Intangible Assets

Intangible assets at December 31 consist of the following:

	2002	2001
Goodwill	$ 6,255	$ 2,464
Purchased contract rights	3,885	1,410
Provider contracts	2,400	—
Total intangibles	12,540	3,874
Less accumulated amortization:		
Goodwill	(1,233)	(1,233)
Purchased contract rights	(592)	(245)
Provider contracts	(20)	—
Total accumulated amortization	(1,845)	(1,478)
Intangible assets, net	$10,695	$ 2,396

Amortization expense was $367, $648 and $224 for the years ended December 31, 2002, 2001 and 2000, respectively. The estimated amortization expense for each of the next five years, assuming no further acquisitions, is approximately $800.

7. Income Taxes

Centene files a consolidated federal income tax return while Centene and each subsidiary file separate state income tax returns.

The consolidated income tax expense (benefit) consists of the following for the years ended December 31:

	2002	2001	2000
Current:			
Federal	$13,661	$7,952	$ 629
State	2,338	1,624	625
Total current	15,999	9,576	1,254
Deferred	(368)	(445)	(1,797)
Total expense (benefit)	$15,631	$9,131	$ (543)

The following is a reconciliation of the expected income tax expense (benefit) as calculated by multiplying pretax income by federal statutory rates and Centene's actual income tax benefit for the years ended December 31:

	2002	2001	2000
Expected federal income tax expense	$14,398	$7,709	$ 2,443
State income taxes, net of federal income tax benefit	1,520	1,141	412
Tax exempt investment income	(411)	—	—
Equity in losses of joint ventures, net of tax	—	—	175
Change in valuation allowance	—	—	(3,764)
Other, net	124	281	191
Income tax expense (benefit)	$15,631	$9,131	$ (543)

Federal statutory rates for the years ended December 31, 2002, 2001 and 2000 were 35%, 35% and 34%, respectively.

Temporary differences that give rise to deferred tax assets and liabilities are presented below for the years ended December 31:

	2002	2001
Medical claims liabilities and other accruals	$3,848	$2,279
Allowance for doubtful accounts	81	1,435
Depreciation and amortization	702	353
Other	8	18
Total deferred tax assets	4,639	4,085
Other	1,321	782
Total deferred tax liabilities	1,321	782
Net deferred tax assets and liabilities	$3,318	$3,303

The Company is required to record a valuation allowance when it is more likely than not that some portion or all of the deferred tax assets will not be realized. Management determined that a valuation allowance was no longer necessary for its federal net operating loss carryforward as of December 31, 2000. As a result, the income tax benefit recorded for 2000 includes the reversal of $3,764 of deferred tax valuation allowance.

8. Medical Claims Liabilities

The change in medical claims liabilities is summarized as follows:

	2002
Balance, January 1	$ 59,565
Acquisitions	16,230
Incurred related to:	
Current year	399,141
Prior years	(19,673)
Total incurred	379,468
Paid related to:	
Current year	326,636
Prior years	37,446
Total paid	364,082
Balance, December 31	$ 91,181

Acquisitions in 2002 include reserves acquired in connection with the Company's acquisition of 80% of the outstanding capital stock of UHP.

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

The Company had reinsurance recoverables related to paid and unpaid medical claims liabilities of $2,738 and $1,202 at December 31, 2002 and 2001, respectively, included in premiums and other receivables.

9. Revolving Line of Credit

In May 2002, the Company entered into a $25,000 revolving line of credit facility with LaSalle Bank N.A. The line of credit has a term of one year and has interest rates based on prime, floating and LIBOR rates. The Company granted a security interest in the common stock of its subsidiaries. The facility includes financial covenants, including requirements of minimum EBITDA and minimum tangible net worth. The Company is required to obtain LaSalle's consent of any proposed acquisition that would result in a violation of any of the covenants contained in the line of credit. As of December 31, 2002, no funds had been drawn on the facility.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS *(continued)*

Dollars in thousands, except share data

10. Notes Payable and Subordinated Debt

As of December 31, 2002 and 2001, the Company has no outstanding debt.

During 2001 and 2000, the Company had subordinate promissory notes with principal balances due ranging from $0 to $4,000. Interest was due and payable annually in September at a rate of 8.5%. In the event that the Company did not comply with the terms of the subordinated promissory notes, the Company would be considered to be in default on its debt and the interest rate would be 10.5%.

During 2000, the Company was in default on its promissory notes due to late interest payments. In December 2001, all of the promissory notes and related accrued interest were paid in full. Interest expense for the years ended December 31, 2001 and 2000 was $362 and $611, respectively.

11. Redeemable Preferred Stock

Upon completion of the Company's IPO in December 2001, all outstanding shares of Series D redeemable preferred stock were converted into 3,716,000 shares of common stock.

Series D preferred stock was convertible, at the option of the holder, into common stock at an initial conversion rate of one common share for each preferred share and was automatically converted at an initial public offering. Series D preferred stock was redeemable for cash at the option of the holder for up to 50% of that holder's Series D preferred stock outstanding on each of September 1, 2003, and September 1, 2004, at a price equal to the sum of (1) $5.50 per share plus (2) an amount equal to any dividends declared or accrued but unpaid on such shares. Series D preferred stock was entitled to an initial liquidation preference in the amount of $5.00 per share.

Redeemable preferred stock is summarized as follows:

	Series D Shares	Amount
Balance, December 31, 1999	3,718,000	$ 18,386
Preferred stock accretion	—	492
Balance, December 31, 2000	3,718,000	18,878
Preferred stock accretion	—	467
Purchase of stock	(2,000)	(16)
Conversion to common	(3,716,000)	(19,329)
Balance, December 31, 2001	—	—
Purchase of stock	—	—
Conversion to common	—	—
Balance, December 31, 2002	—	$ —

12. Stockholders' Equity

Upon completion of the Company's IPO in December 2001, each outstanding share of each class of common stock and preferred stock was converted into one share of a single class of $.001 par value common stock. Prior to the IPO, the Company had three classes of preferred stock outstanding and included in equity. They were Series A, Series B and Series C preferred stock.

Holders of common stock are entitled to one vote for each share of common stock held.

Effective November 2001, the Company changed its state of incorporation from Wisconsin to Delaware. Under the Delaware Certificate of Incorporation, the Company has 10,000,000 authorized shares of preferred stock at $.001 par value and 40,000,000 authorized shares of common stock at $.001 par value. At December 31, 2002, there were no preferred shares outstanding.

During 2001, Centene had warrants outstanding to purchase 60,000 shares of the Company's Series D preferred stock at an exercise price of $5.00 per share. In addition, there were warrants outstanding to purchase 7,432 of the Company's common stock at an exercise price of $2.40 per share. Prior to the completion of the Company's IPO, all outstanding warrants were exercised.

13. Statutory Capital Requirements

Various state laws require Centene's subsidiaries to maintain minimum capital requirements. At December 31, 2002 and 2001, Centene's subsidiaries had aggregate statutory capital and surplus of $36,900 and $16,300, respectively, compared with the required minimum aggregate statutory capital and surplus of $22,000 and $9,100, respectively.

14. Dividend Restrictions

Under the laws of the states of which the Company operates, the Company's regulated subsidiaries are required to obtain approval for dividends from the appropriate state regulatory body. The Company received dividends of $4,000 from its managed care subsidiaries during 2002. No dividends were declared in 2001 or 2000.

15. Stock Option Plans

As of December 31, 2002, Centene had five stock option plans (the Plans) for issuance of common stock. The Plans allow for the granting of options to purchase common stock at the market price at the date of grant for key employees, consultants, and other individual contributors of or to Centene. Both incentive options and nonqualified stock

options can be awarded under the Plans. Each option awarded under the Plans is exercisable as determined by the Board of Directors upon grant. Further, depending on the type of grant, no option will be exercisable for longer than ten years after date of grant. The Plans have reserved 2,200,000 shares for option grants. Options granted generally vest over a five-year period. Vesting generally begins on the anniversary of the date of grant and annually thereafter.

Option activity for the years ended December 31 is summarized below:

	2002		2001		2000	
	Shares	Weighted Average Exercise Price	Shares	Weighted Average Exercise Price	Shares	Weighted Average Exercise Price
Options outstanding, beginning of year	1,422,940	$ 2.65	1,410,040	$ 1.68	955,992	$1.91
Granted	487,500	24.82	139,000	11.99	531,000	1.26
Exercised	(277,400)	1.65	(19,100)	1.71	—	—
Canceled	(79,400)	10.98	(107,000)	1.82	(76,952)	1.69
Options outstanding, end of year	1,553,640	$ 9.38	1,422,940	$ 2.67	1,410,040	$1.68
Weighted average remaining life	7.4 years		7.6 years		7.7 years	
Weighted average fair value of options granted	$15.07		$5.59		$0.37	

The following table summarizes information about options outstanding as of December 31, 2002:

	Options Outstanding			Options Vested	
Range of Exercise Prices	Options Outstanding	Weighted Average Remaining Contractual Life	Weighted Average Exercise Price	Options Exercisable	Weighted Average Exercise Price
$ 0.00–$ 3.43	988,040	6.2	$ 1.74	576,440	$ 1.99
$ 3.44–$ 6.87	13,800	8.2	5.25	1,000	5.25
$ 6.88–$10.30	25,000	8.7	7.78	6,250	7.78
$10.31–$13.73	—	—	—	—	—
$13.74–$17.17	61,800	9.0	16.26	8,400	16.98
$17.18–$20.60	5,000	9.1	18.86	—	—
$20.61–$24.03	288,000	9.5	22.57	4,250	20.71
$24.04–$27.46	44,000	9.7	25.66	—	—
$27.47–$30.90	94,500	9.6	29.43	—	—
$30.91–$34.33	33,500	10.0	32.13	—	—
	1,553,640	7.4	$ 9.38	596,340	$ 2.40

The Company accounts for the Plans in accordance with the intrinsic value based method of Accounting Principles Board Opinion No. 25 as permitted by SFAS No. 123. Accordingly, compensation cost related to stock options issued to employees is calculated on the date of grant only if the current market price of the underlying stock exceeds the exercise price. Compensation expense is then recognized on a straight-line basis over the years the employees' services are received (over the vesting period), generally five years. No compensation cost related to the Plans was charged against income during 2000. During 2002 and 2001, the Company recognized $270 and $6, respectively, in noncash

Dollars in thousands, except share data

compensation expense related to the issuance of stock options. Had compensation cost for the Plans been determined based on the fair value method at the grant dates as specified in SFAS No. 123, Centene's net earnings would have been reduced to the following pro forma amounts:

	2002	2001	2000
Net earnings, as reported	$25,621	$12,895	$7,728
Accretion of redeemable preferred stock	—	(467)	(492)
Net earnings attributable to common stockholders	25,621	12,428	7,236
Total stock-based employee compensation expense determined under fair value based method, net of related tax effects	6,170	665	110
Pro forma net earnings	$19,451	$11,763	$7,126
Earnings Per Common Share:			
Basic, as reported	$ 2.45	$ 8.97	$ 8.03
Basic, pro forma	1.86	8.49	7.90
Diluted, as reported	$ 2.20	$ 1.61	$ 1.13
Diluted, pro forma	1.67	1.53	1.12
Shares Used in Computing Per Share Amounts:			
Basic	10,447,360	1,385,399	901,526
Diluted	11,644,077	8,019,497	6,819,595

The fair value of each option grant is estimated on the date of the grant using an option pricing model with the following assumptions: no dividend yield; expected volatility of 1% through the date of the IPO; 50% through the end of 2001; and 54% for 2002, risk-free interest rate of 3.6%, 4.9% and 5.3% and expected lives of 7.4, 7.6 and 7.7 for the years ended December 31, 2002, 2001 and 2000, respectively.

During 2002, Centene implemented an employee stock purchase plan. Under this plan, eligible employees are permitted to purchase shares of the Company's common stock at a discounted price through payroll withholdings. At the end of each plan period, the Company issues stock to participating employees at a price equal to 85% of the lesser of the closing stock price on either the first business day of the plan period or the exercise date. The Company has reserved 300,000 shares of common stock and issued 1,792 shares in 2002.

16. Retirement Plan

Centene has a defined contribution plan (Retirement Plan) which covers substantially all employees who work at least 1,000 hours in a twelve consecutive month period and are at least twenty-one years of age. Under the Retirement Plan, eligible employees may contribute a percentage of their base salary, subject to certain limitations. Centene may elect to match a portion of the employee's contribution. In addition, Centene may make a profit sharing contribution to the Retirement Plan covering all eligible employees. Expenses under the Retirement Plan were $312, $306 and $203 during the years ended December 31, 2002, 2001 and 2000, respectively.

During 2002, Centene implemented an executive retirement savings plan (Executive Plan). This Plan is a voluntary, non-qualified deferred compensation plan designed to provide executive employees with tax-deferred savings opportunities. Under the Executive Plan, eligible employees may contribute a percentage of their base salary, subject to certain limitations.

17. Related-Party Transactions

No related party transactions occurred in 2002. Certain members of Centene's Board of Directors performed consulting services for the Company totaling $3 in 2001 and $36 in 2000. Legal fees of $94 and $48 were paid in 2001 and 2000, respectively, to a law firm affiliated through a stockholder of the Company.

18. Commitments

Centene and its subsidiaries lease office facilities and various equipment under noncancelable operating leases. In addition to base rental costs, Centene and its subsidiaries are responsible for property taxes and maintenance for both facility and equipment leases. Rental expense was $2,109, $1,704 and $1,383 for the years ended December 31, 2002,

2001 and 2000, respectively. The significant annual noncancelable lease payments over the next five years and thereafter are as follows:

2003	$ 3,241
2004	3,124
2005	3,026
2006	2,661
2007	2,396
Thereafter	7,624
	$22,072

19. Risks and Uncertainties

The Company is a party to various legal actions normally associated with the managed care industry, the aggregate effect of which is presently unknown.

The Company's profitability depends in large part on accurately predicting and effectively managing medical services costs. The Company continually reviews its premium and benefit structure to reflect its underlying claims experience and revised actuarial data; however, several factors could adversely affect the medical services costs. Certain of these factors, which include changes in healthcare practices, inflation, new technologies, major epidemics, natural disasters and malpractice litigation, are beyond any health plan's control and could adversely affect the Company's ability to accurately predict and effectively control healthcare costs. Costs in excess of those anticipated could have a material adverse effect on the Company's results of operations.

Financial instruments that potentially subject the Company to concentrations of credit and interest rate risks consist primarily of cash and cash equivalents, investments in marketable securities and accounts receivable. The Company invests its excess cash in interest bearing deposits with major banks, commercial paper, government and agency securities, and money market funds. Investments in marketable securities are managed within guidelines established by the Company's Board of Directors. The Company carries these investments at fair value.

Concentrations of credit risk with respect to accounts receivable are limited due to significant customers paying as services are rendered. Significant customers include the federal government and the states in which Centene operates. The Company has a risk of incurring loss if its allowance for doubtful accounts is not adequate.

As discussed in Note 3 to the consolidated financial statements, the Company has reinsurance agreements with insurance companies. The Company monitors the insurance companies' financial ratings to determine compliance with standards set by state law. The Company has a credit risk associated with these reinsurance agreements to the extent the reinsurers are unable to pay valid reinsurance claims of the Company.

20. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per share for the years ended December 31:

	2002	2001	2000
Net earnings	$25,621	$12,895	$7,728
Accretion of redeemable preferred stock	—	(467)	(492)
Net earnings attributable to common stockholders	$25,621	$12,428	$7,236
Shares used in computing per share amounts:			
Weighted average number of common shares outstanding	10,477,360	1,385,399	901,526
Dilutive effect of stock options and warrants (as determined by applying the treasury stock method) and convertible preferred stock	1,166,717	6,634,098	5,918,069
Weighted average number of common shares and potential dilutive common shares outstanding	11,644,077	8,019,497	6,819,595
Earnings Per Common Share, Basic:			
Net earnings per common share	$ 2.45	$ 8.97	$ 8.03
Earnings Per Common Share, Diluted:			
Net earnings per common share	$ 2.20	$ 1.61	$ 1.13

Dollars in thousands, except share data

21. Joint Ventures—University Health Plans, Inc.

On December 1, 2002, Centene purchased 80% of the outstanding capital stock of University Health Plans, Inc. UHP is a managed health plan serving approximately 53,000 Medicaid members in 15 counties throughout New Jersey. Centene paid approximately $10,630 in cash and expenses. In accordance with terms in the agreement, the purchase price may be adjusted based on certain conditions up to one year after the acquisition date. The results of operations for UHP are included in the consolidated financial statements since December 1, 2002. Centene will operate UHP as a joint venture with the third-party owner, and Centene will manage UHP's operations in a manner consistent with its other Medicaid health plans. The joint venture investment is consistent with Centene's strategy to enter new markets where it sees an opportunity for organic growth in Medicaid managed care.

The stock purchase agreement provides terms for Centene's future purchase of the remaining 20% of UHP's outstanding capital stock. This future purchase is in the form of a call and put option. The call option allows Centene to purchase the additional 20% of outstanding shares for cash within nine months after the original acquisition date at an aggregate purchase price of $2,600. The put option requires the third-party owner to transfer, convey, assign and deliver the additional 20% of outstanding common stock to Centene on the third anniversary following the original acquisition date. The put option allows Centene to acquire the additional shares based on its "deemed value" at such point in time. The "deemed value" is defined as an amount equal to the greater of (i) $2,600 or (ii) the enterprise value, as established by mutual agreement of the parties, of UHP as of the date of exchange multiplied by the percentage of the outstanding common stock.

The condensed balance sheet below includes the purchase price allocation at the acquisition date. Goodwill is not amortized and is not deductible for tax purposes. The state contract and provider network will be amortized over a ten-year period. The value of the common stock acquired is being determined based on the fair value of tangible assets and liabilities acquired as well as external valuations of identifiable intangible assets.

Centene is in the process of obtaining third-party valuations related to certain intangible assets, including the value associated with the options to purchase the remaining 20% of UHP's outstanding common stock; thus, the allocation of the purchase price is subject to refinement.

Assets	
Cash and cash equivalents	$ 3,324
Premium and related receivables	6,604
Other current assets	215
Property and equipment, net	468
Restricted deposits	12,173
Intangible assets:	
Goodwill	3,791
Purchased contract rights	1,400
Provider network	2,400
Total assets	$30,375
Liabilities and Stockholders' Equity	
Accrued medical claims	$16,230
Accounts payable and accrued liabilities	2,518
Minority interest	997
Stockholders' equity	10,630
Total liabilities and stockholders' equity	$30,375

The following unaudited pro forma information presents the results of operations of Centene and subsidiaries as if the acquisition described above had occurred as of January 1, 2001. Effective July 1, 2002, the state of New Jersey excluded the General Assistance population from managed care programs. In addition, effective November 22, 2002, in contemplation of its Stock Purchase Agreement with Centene, UHP entered into an agreement with a third party related to its commercial membership. Any members not enrolling with the third party will not be renewed by UHP. As a result, pro forma adjustments include UHP earnings before taxes excluding the financial results of the General Assistance population and the commercial membership. In addition, the pro forma adjustments include the amortization of intangibles, excluding goodwill, before taxes of $348 in 2002 and $380 in 2001. The pro forma adjustments to earnings are net of taxes at Centene's effective tax rates and have been adjusted for the 20% minority interest in UHP by a third party. These pro forma results may not necessarily reflect the actual results of operations that would have been achieved, nor are they necessarily indicative of future results of operations.

	2002	2001
Revenue	$567,048	$395,155
Net earnings before accretion of redeemable preferred stock	25,986	12,305
Net earnings	25,986	11,838
Basic earnings per share	2.48	8.54
Diluted earnings per share	2.23	1.53

22. Joint Ventures—Superior HealthPlan Inc.

From 1998 through 2000, Centene owned 39% of Superior and, therefore, accounted for the investment under the equity method of accounting. Superior participates in the state of Texas medical assistance program. Superior had no enrolled membership during 1998, but became fully operational on December 1, 1999. Under the terms of a management agreement, a wholly owned subsidiary of Centene performs third-party administrative services for Superior. This agreement generated $4,936 of administrative service fees during 2000.

Summary financial information for Superior as of and for the year ended December 31 follows:

	2000
Total assets	$ 7,284
Stockholders' deficit	(1,481)
Revenues	34,102
Net loss	(1,303)
Company's equity in net loss	(508)

Effective January 1, 2001, Centene purchased an additional 51% of Superior for $290 in cash, increasing Centene's ownership to 90%. Centene began consolidating Superior's operations from that point forward. When the change in ownership occurred, goodwill of $1,200 was recorded as part of the transaction. In December 2001, Centene purchased the remaining shares of Superior for $100 in stock, increasing Centene's ownership to 100%. At December 31, 2001, all intercompany transactions between Centene and Superior have been eliminated in consolidation.

The following unaudited pro forma summary information presents the consolidated statement of earnings information as if the aforementioned transaction had been consummated on January 1, 2000, and does not purport to be indicative of what would have occurred had the acquisition been made at that date or of the results which may occur in the future.

	Year Ended December 31, 2000
Total revenues	$250,516
Net earnings attributable to common stockholders	6,441
Diluted net earnings per common share	.94

23. Contract Acquisitions

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

In December 2000, MHSIC and Superior entered into agreements with Humana Inc. to transfer Humana's Medicaid contract with the state of Wisconsin to MHSIC and Humana's Medicaid contract with the state of Texas to Superior. Effective February 1, 2001, the state of Wisconsin approved the agreement, thereby allowing MHSIC to serve approximately 35,000 additional members in the state. Effective February 1, 2001, the state of Texas approved a management agreement between Superior and Humana Inc., thereby allowing Superior to manage approximately 30,000 additional members in Texas. As a result of these transactions, $1,250 was recorded as an intangible asset purchased contract rights. Centene is amortizing the contract rights on a straight-line basis over five years, the period expected to be benefited.

24. Bankers Reserve Acquisition

On March 14, 2002, the Company completed an acquisition of Bankers Reserve Life Insurance Company of Wisconsin (Bankers Reserve) for a cash purchase price of $3,527. The Company allocated the purchase price to net tangible and identifiable intangible assets based on their fair value. Centene allocated $479 to identifiable intangible assets, representing the value assigned to acquired licenses, which are being amortized on a straight-line basis over a period of ten years. The Company accounted for this acquisition under the purchase method of accounting and accordingly, the consolidated results of operations include the results of the acquired Bankers Reserve business from the date of acquisition. The Company has excluded pro forma disclosures related to the impact of Bankers Reserve on the results of operations for the twelve-month period ended December 31, 2002, as well as the comparable period in the preceding

year. Such disclosures have been excluded as there are no significant continuing operations as of the date of acquisition, outside of the run-off of Separate Account activity.

As part of the acquisition, the Company acquired $5,200 of Separate Account assets and $5,200 of Separate Account liabilities. The acquired Separate Account assets and liabilities represent fixed rate annuity contracts with various maturity dates. Concurrent with the acquisition of Bankers Reserve, the Company entered into a 100% coinsurance reinsurance agreement with an unaffiliated party to reinsure the guaranteed cash value, annuity benefit, surrender benefit and death benefits associated with these contracts. The reinsurance premiums paid for this coverage equal the net administrative fee earned and received by the Company on the annuity contracts. Accordingly, there is no income statement impact to the Company as a result of acquiring the Separate Account assets and liabilities. The Separate Account balances, which are being liquidated and paid to insureds as annuities mature, do not have a minimum guarantee benefit beyond the cash surrender value of the policy.

Centene acquired Bankers Reserve for the purpose of providing reinsurance coverage to its existing managed care Medicaid entities. It is not currently anticipated that Bankers Reserve would be used to offer reinsurance to unaffiliated entities.

The intercompany reinsurance activity is eliminated on a consolidated basis.

CERTIFICATIONS

I, Michael F. Neidorff, certify that:

1. I have reviewed this annual report on Form 10-K of Centene Corporation;

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

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

4. Karey L. Witty, the Senior Vice President, Chief Financial Officer and Treasurer of Centene Corporation, and I:

   —are responsible for establishing and maintaining disclosure controls and procedures (as defined for purposes of Rule 13a-14 under the Securities and Exchange Act of 1934, as amended) for Centene Corporation;

   —have designed such disclosure controls and procedures to ensure that material information relating to Centene Corporation, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this annual report was prepared;

   —have evaluated the effectiveness of the disclosure controls and procedures of Centene Corporation as of a date within 90 days prior to the filing date of this annual report; and

   —have presented in this annual report our conclusions about the effectiveness of the disclosure controls and procedures based on the required evaluation as of that date;

5. Mr. Witty and I have disclosed, based on our most recent evaluation, to the auditors of Centene Corporation and to the audit committee of the board of directors of Centene Corporation:

   —all significant deficiencies in the design or operation of internal controls that could adversely affect the ability of Centene Corporation to record, process, summarize and report financial data and have identified for such auditors any material weaknesses in internal controls; and

   —any fraud, whether or not material, that involves management or other employees who have a significant role in the internal controls of Centene Corporation; and

6. Mr. Witty and I have indicated in this annual report whether or not there were significant changes in internal controls or in other factors that could significantly affect internal controls subsequent to the date of our evaluation, including any corrective actions with regard to significant deficiencies and material weaknesses.

/s/ MICHAEL F. NEIDORFF

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

Date: February 24, 2003

CERTIFICATIONS

I, Karey L. Witty, certify that:

1. I have reviewed this annual report on Form 10-K of Centene Corporation;

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

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

4. Mr. Michael F. Neidorff, the President and Chief Executive Officer of Centene Corporation, and I:

   —are responsible for establishing and maintaining disclosure controls and procedures (as defined for purposes of Rule 13a-14 under the Securities and Exchange Act of 1934, as amended) for Centene Corporation;

   —have designed such disclosure controls and procedures to ensure that material information relating to Centene Corporation, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this annual report was prepared;

   —have evaluated the effectiveness of the disclosure controls and procedures of Centene Corporation as of a date within 90 days prior to the filing date of this annual report; and

   —have presented in this annual report our conclusions about the effectiveness of the disclosure controls and procedures based on the required evaluation as of that date;

5. Mr. Neidorff and I have disclosed, based on our most recent evaluation, to the auditors of Centene Corporation and to the audit committee of the board of directors of Centene Corporation:

   —all significant deficiencies in the design or operation of internal controls that could adversely affect the ability of Centene Corporation to record, process, summarize and report financial data and have identified for such auditors any material weaknesses in internal controls; and

   —any fraud, whether or not material, that involves management or other employees who have a significant role in the internal controls of Centene Corporation; and

6. Mr. Neidorff and I have indicated in this annual report whether or not there were significant changes in internal controls or in other factors that could significantly affect internal controls subsequent to the date of our evaluation, including any corrective actions with regard to significant deficiencies and material weaknesses.

/s/ KAREY L. WITTY

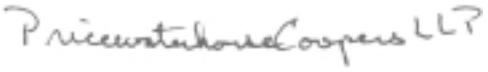
Karey L. Witty
Senior Vice President, Chief Financial Officer
and Treasurer
(principal financial and
accounting officer)

Date: February 24, 2003

To the Board of Directors and
Stockholders of Centene Corporation:

In our opinion, the accompanying consolidated balance sheet as of December 31, 2002, and the related consolidated statement of earnings, stockholders' equity and cash flows present fairly, in all material respects, the financial position of Centene Corporation and its subsidiaries (the "Company") at December 31, 2002, and the results of their operations and their cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America. These financial statements are the responsibility of the Company's management; our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit of these statements in accordance with auditing standards generally accepted in the United States of America, which 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, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion. The financial statements of the Company as of December 31, 2001, and for each of the two years in the period ended December 31, 2001, were audited by other independent accountants who have ceased operations. Those independent accountants expressed an unqualified opinion on those financial statements in their report dated February 1, 2002.

As discussed in Note 3 to the consolidated financial statements, in 2002 the Company changed its method of accounting for goodwill to conform with Statement of Financial Accounting Standards No. 142, "Goodwill and Other Intangible Assets."



PRICEWATERHOUSECOOPERS LLP
St. Louis, Missouri
February 14, 2003

REPORT OF INDEPENDENT PUBLIC ACCOUNTANTS

The following report is a copy of a report previously issued by Arthur Andersen LLP and has not been reissued by Arthur Andersen LLP.

To Centene Corporation:

We have audited the accompanying consolidated balance sheets of Centene Corporation (a Delaware corporation) and subsidiaries as of December 31, 2001 and 2000, and the related consolidated statements of earnings, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2001. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the 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, 2001 and 2000, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2001, in conformity with accounting principles generally accepted in the United States.

/S/ ARTHUR ANDERSEN LLP
St. Louis, Missouri
February 1, 2002

CORPORATE INFORMATION

BOARD OF DIRECTORS

Samuel E. Bradt
President, Merganser Corporation

Edward L. Cahill
Partner, HLM Management

Robert K. Ditmore
Former President and COO, United Healthcare Corp.

Claire W. Johnson
Chairman of the Board, Centene Corporation

Michael F. Neidorff
President and CEO, Centene Corporation

Richard P. Wiederhold
President and CEO, Elizabeth A. Brinn Foundation

SENIOR MANAGEMENT

Michael F. Neidorff
President and CEO

Joseph P. Drozda, Jr., M.D.
Sr. VP, Medical Affairs

Carol E. Goldman
VP and Chief Administrative Officer

Catherine M. Halverson
Sr. VP, Business Development

Cary D. Hobbs
VP, Strategy and Business Implementation

Robert C. Packman, M.D.
VP, Chief Medical Officer

Daniel R. Paquin
Sr. VP, Health Plan Business Group

Brian G. Spanel
Sr. VP and Chief Information Officer

John D. Tadich
Sr. VP, Specialty Companies

Karey L. Witty
Sr. VP and Chief Financial Officer

FIELD OFFICERS

Christopher Bowers
President and CEO, Superior HealthPlan

Kathleen R. Crampton
President and CEO, MHS Wisconsin

Rita Johnson-Mills
President and CEO, MHS Indiana

Alexander H. McLean
President and CEO, University Health Plans, Inc.

Robert J. Nolan
VP, Regulatory Network Development and Integration, Centene Corporation

OFFICERS

Judy Bauer
VP, Care Management

Cynthia P. Jansky
VP, Human Resources

James E. Reh
VP, Facilities Management

Joann Taylor
VP, Member Affairs

CORPORATE AND INVESTOR INFORMATION

CORPORATE HEADQUARTERS
Centene Corporation
7711 Carondelet Avenue, Suite 800
St. Louis, Missouri 63105
314-725-4477
www.centene.com

FORM 10-K

The company has filed an Annual Report on Form 10-K for the year ended December 31, 2002 with the Securities and Exchange Commission. Stockholders may obtain a copy of this report, without charge, by writing:

Investor Relations
Centene Corporation
7711 Carondelet Avenue, Suite 800
St. Louis, Missouri 63105

COMMON STOCK INFORMATION

Centene common stock is quoted on the Nasdaq National Market® under the symbol "CNTE." The following table shows the quarterly range of high and low sales prices of the common stock since the Company's initial public offering on December 13, 2001:

		High	Low
2001	Fourth	23.10	14.27
2002	First	23.56	18.10
	Second	31.09	22.61
	Third	30.67	21.70
	Fourth	35.48	25.45

DIVIDEND POLICY

The Company has not paid any dividends on its common stock, and expects that its earnings will continue to be retained for use in the operation and expansion of its business.

ANNUAL MEETING

The Annual Meeting of Shareholders will be held on Monday, May 6, 2003 at 10:00 a.m. at The Ritz Carlton St. Louis, 100 Carondelet Plaza, St. Louis, MO 63105 in the Plaza Room, 314-863-6300.

TRANSFER AGENT

Mellon Investor Services
P.O. Box 590
Ridgefield Park, New Jersey 07660
800-227-0291
www.melloninvestor.com

Designed by Curran & Connors, Inc. / www.curran-connors.com

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