CENTENE CORP
Form 10-K
February 23, 2007

SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

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

For the fiscal year ended December 31, 2006

or

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

For the transition period from to

Commission file number: 000-33395

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

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

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

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

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

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

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

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

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

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filed, or a non-accelerated filer. See definition of "accelerated filer and large accelerated filer" in rule 12b-2 of the Exchange Act. Large accelerated filer T Accelerated filer £ Non-accelerated filer £

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 30, 2006, was $995,902,615.

As of December 31, 2006 the registrant had 43,369,918 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2007 annual meeting of stockholders are incorporated by reference in Part II, Item 5 and Part III, Items 10, 11, 12, 13 and 14.

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Part I

Our trademark, service marks and trade names referred to in this filing include AirLogix, Bridgeway, Buckeye Community Health Plan, Cardium Health, Cenpatico Behavioral Health, Cenpatico Behavioral Health of Arizona, Centene, FirstGuard Health Plan, Managed Health Services, NurseWise, OptiCare, *Script*Assist, Smart Start For Your Baby, US Script and University Health Plans, among others.

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PART I

Item 1. ***Business***

OVERVIEW

We are a multi-line healthcare enterprise operating primarily in two segments: Medicaid Managed Care and Specialty Services. Our Medicaid Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program, or SCHIP, and Supplemental Security Income, or SSI. Medicaid currently accounts for 79% of our membership, while SCHIP and SSI account for 19% and 2%, respectively. Our Specialty Services segment provides specialty services, including behavioral health, disease management, long-term care programs, managed vision, nurse triage, pharmacy benefits management and treatment compliance, to state programs, healthcare organizations and other commercial organizations, as well as to our own subsidiaries on market-based terms. Our FirstGuard health plans exited the Kansas and Missouri markets effective January 1 and February 1, 2007, respectively.

Our Medicaid Managed Care membership totaled approximately 1.3 million as of December 31, 2006, an increase of 45% from December 31, 2005. That membership includes 107,000 and 31,900 members in Kansas and Missouri, respectively. We currently have six health plan subsidiaries offering healthcare services in Georgia, Indiana, New Jersey, Ohio, Texas and Wisconsin. We provide member-focused services through locally based staff by assisting in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services.

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

Our initial health plan commenced operations in Wisconsin in 1984. We were organized in Wisconsin in 1993 as a holding company for our initial health plan and reincorporated in Delaware in 2001. Our corporate office is located at 7711 Carondelet Avenue, St. Louis, Missouri 63105, and our telephone number is (314) 725-4477.

We maintain a website with the address *www.centene.com.* We are not including the information contained on our website as part of, or incorporating it by reference into, this filing. We make available, free of charge through our website, our Section 16 filings, annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K, and any amendments to these reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act as soon as reasonably practicable after we electronically file such material with, or furnish such material to, the SEC.

INDUSTRY

We provide our services to organizations and individuals primarily through Medicaid, SCHIP and SSI programs. The Congressional Budget Office, or CBO, estimated the total Medicaid market was approximately $330 billion in 2005, and the federal Centers for Medicare and Medicaid Services, or CMS, estimate the market will grow to over $450 billion by 2010. According to the most recent information provided by the Kaiser Commission on Medicaid and the

Uninsured, Medicaid spending increased by 2.8% in fiscal 2006 and states appropriated an increase of 5.0% for Medicaid in fiscal 2007 budgets.

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

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

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

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

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

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

OUR COMPETITIVE STRENGTHS

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

- *Sustained Historic Operating Performance*. We have a historical trend of increasing revenues as we have grown in existing markets and expanded into new markets. We entered the Wisconsin market in 1984, the Indiana market in 1995, the Texas market in 1999, the New Jersey market in 2002, the Ohio market in 2004 and the Georgia market in 2006. We have also increased membership by acquiring Medicaid businesses, contracts and other related assets from competitors in existing markets, most recently in Ohio in 2005 and 2006. We have increased our total membership from 409,600 in 2002 to 1,262,200 as of December 31, 2006, a 32% Compound Annual Growth Rate, or CAGR. For the year ended December 31, 2006, we had revenue of $2.3 billion, representing a 49% CAGR since the year ended December 31, 2002. We generated total cash flow from operations of $195.0 million during the year ended December 31, 2006.

- *Medicaid Expertise.* Over the last 20 years, we have strived to develop a specialized Medicaid expertise that has helped us establish and maintain relationships with members, providers and state governments. We have implemented programs developed to achieve savings for state governments and improve medical outcomes for members by reducing inappropriate emergency room use, inpatient days and high cost interventions, as well as by

managing care of chronic illnesses. Our experience in working with state regulators helps us implement and deliver programs and services efficiently and affords us opportunities to provide input regarding Medicaid industry practices and policies in the states in which we operate. We work with state agencies on redefining benefits, eligibility requirements and provider fee schedules in order to maximize the number of uninsured individuals covered through Medicaid, SCHIP and SSI and expand these types of benefits offered. Our approach is to accomplish this while maintaining adequate levels of provider compensation and protecting our profitability.

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

Ÿ *Localized Approach with Centralized Support Infrastructure.* We take a localized approach to managing our subsidiaries, including provider and member services. This approach enables us to facilitate access by our members to high quality, culturally sensitive healthcare services. Our systems and procedures have been designed to address these community-specific challenges through outreach, education, transportation and other member support activities. For example, our community outreach programs work with our members and their communities to promote health and self-improvement

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through employment and education on how best to access care. We complement this localized approach with a centralized infrastructure of support functions such as finance, information systems and claims processing, which allows us to minimize general and administrative expenses and to integrate and realize synergies from acquisitions. We believe this combined approach allows us to efficiently integrate new business opportunities in both Medicaid and specialty services while maintaining our local accountability and improved access.

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

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

OUR STRATEGY

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

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

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

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

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

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

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

MEDICAID MANAGED CARE

Health Plans

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

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

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

Benefits to States

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

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

Ÿ *Data-driven approaches to balance cost and verify eligibility*