CENTENE CORP
Form 424B5
January 22, 2010

Table of Contents

CALCULATION OF REGISTRATION FEE

Title of each class of securities to be registered	Amount to be registered	Proposed maximum offering price per unit	Proposed maximum aggregate offering price(1)	Amount of registration fee(2)
Common Stock, par value $.001 per share	5,750,000(1)	$19.25	$110,687,500	$7,892.02

(1) Includes shares that may be purchased by the underwriters to cover overallotments, if any.

(2) The registration fee of $7,892.02 is calculated in accordance with Rule 457(r) and shall be paid on a deferred basis in accordance with Rule 456(b).

Filed Pursuant to Rule 424(b)(5)
Registration No. 333-164390

PROSPECTUS SUPPLEMENT
(To prospectus dated January 19, 2010)

5,000,000 Shares

Centene Corporation
Common Stock

Centene Corporation is offering 5,000,000 shares of common stock to be sold pursuant to this prospectus supplement and the accompanying prospectus. We intend to use the proceeds of this offering to repay indebtedness and for general corporate purposes. See Use of Proceeds. Our common stock is listed on the New York Stock Exchange under the symbol CNC. On January 21, 2010, the last sale price of our common stock as reported on the New York Stock Exchange was $19.41 per share.

Investing in our common stock involves risks that are described in the Risk Factors section beginning on page S-11 of this prospectus supplement.

	Per Share	Total
Public offering price	$ 19.2500	$ 96,250,000
Underwriting discount	$ .9625	$ 4,812,500
Proceeds, before expenses, to us	$ 18.2875	$ 91,437,500

The underwriters may also purchase up to an additional 750,000 shares of common stock from us at the public offering price, less the underwriting discount, within 30 days from the date of this prospectus supplement to cover overallotments.

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

The shares will be ready for delivery on or about January 27, 2010.

Joint Book-Running Managers

BofA Merrill Lynch

Goldman, Sachs & Co.

J.P.Morgan

Credit Suisse

Co-Managers

Barclays Capital

Allen & Company LLC

Stifel Nicolaus

The date of this prospectus supplement is January 21, 2010.

TABLE OF CONTENTS

Prospectus Supplement

Prospectus

You should read this document together with additional information described under the heading Where You Can Find More Information. You should rely only on the information contained or incorporated by reference in this prospectus supplement and the accompanying prospectus. We have not, and the underwriters have not, authorized any other person to provide you with different information. If anyone provides you with different or inconsistent information, you should not rely on it. We are not, and the underwriters are not, making an offer to sell these securities in any jurisdiction where the offer or sale is not permitted. You should assume that the information appearing in this prospectus supplement, the accompanying prospectus and the documents incorporated by reference is accurate only as

of their respective dates. Our business, financial condition, results of operations and prospects may have changed since those dates.

Table of Contents

ABOUT THIS PROSPECTUS SUPPLEMENT

This document is comprised of two parts. The first part is the prospectus supplement, which describes the specific terms of this offering and also adds to and updates information contained in the accompanying prospectus and the documents incorporated by reference. The second part is the accompanying prospectus, which gives more general information, some of which may not apply to this offering. Generally, when we refer to the prospectus, we are referring to both parts of this document combined. To the extent there is a conflict between the information contained in this prospectus supplement, on the one hand, and the information contained in the accompanying prospectus, on the other hand, the information in this prospectus supplement shall control.

Unless the context otherwise requires, the terms the Company, we, us, our or similar terms and Centene refer to Centene Corporation, together with its consolidated subsidiaries.

This document may only be used where it is legal to sell the shares of common stock. Certain jurisdictions may restrict the distribution of these documents and the offering of the shares of common stock. We require persons receiving these documents to inform themselves about and to observe any such restrictions. We have not taken any action that would permit an offering of the shares of common stock or the distribution of these documents in any jurisdiction that requires such action.

MARKET AND INDUSTRY DATA

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

Table of Contents

PROSPECTUS SUPPLEMENT SUMMARY

This summary contains basic information about us, our common stock and this offering. Because this is a summary, it does not contain all of the information you should consider before investing in our common stock. You should carefully read this summary together with the more detailed information and financial statements and notes thereto contained elsewhere or incorporated by reference in this prospectus supplement and the accompanying prospectus. To fully understand this offering, you should read all of these documents.

OVERVIEW

We are a multi-line healthcare enterprise operating in two segments: Medicaid Managed Care and Specialty Services. Our Medicaid Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children s Health Insurance Program, or CHIP, Foster Care, Medicare Special Needs Plans and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program, or collectively ABD. As of September 30, 2009, Medicaid accounted for approximately 75% of our at-risk membership, while CHIP (also including Foster Care) and ABD (also including Medicare) accounted for approximately 19% and 6%, respectively. Our Specialty Services segment provides specialty services, including behavioral health, individual health insurance, life and health management, long-term care programs, managed vision, telehealth services, and pharmacy benefits management to state programs, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries. Our Specialty Services segment also provides a full range of healthcare solutions for the rising number of uninsured Americans. For the year ended December 31, 2008, our revenues and net earnings from continuing operations were $3.4 billion and $84.2 million, respectively, and our total cash flow from operations was $222.0 million.

During 2008, we announced our intention to sell certain assets of our New Jersey Health Plan, University Health Plans, Inc. This pending sale is discussed in detail in our Annual Report on Form 10-K for the year ended December 31, 2008, filed with the SEC on February 23, 2009, under the caption Discontinued Operations under Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations and our Quarterly Report on Form 10-Q for the quarterly period ended September 30, 2009, filed with the SEC on October 27, 2009, under the caption Discontinued Operations under Item 2. Management s Discussion and Analysis of Financial Condition and Results of Operations.

Our at-risk managed care membership totaled approximately 1.4 million as of September 30, 2009. 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 generally receive a fixed premium per member per month pursuant to our state contracts. The table below provides summary data for the state markets we served as of September 30, 2009:

State	Local Health Plan Name	First Year of Operations Under the Company	Counties Served at September 30, 2009	Market	At-Risk Managed Care Membership at September 30, 2009

				Share (1)	
Arizona	Bridgeway Health Solutions (2)	2008	1	1.5%	17,400
Florida (3)	Sunshine State Health Plan	2009	9	8.4%	84,400
Georgia	Peach State Health Plan	2006	90	28.3%	303,400
Indiana	Managed Health Services	1995	92	31.7%	200,700
Massachusetts (4)	CeltiCare Health Plan of Massachusetts	2009	6	<0.1%	500
Ohio	Buckeye Community Health Plan	2004	43	10.5%	151,200
South Carolina	Absolute Total Care	2007	42	10.5%	46,100
Texas	Superior HealthPlan	1999	239	22.2%	450,200
Wisconsin	Managed Health Services	1984	33	21.5%	132,500
Total			555		1,386,400

Table of Contents

(1) Represents at-risk Medicaid and CHIP membership as of September 30, 2009 as a percentage of total eligible at-risk Medicaid and CHIP members in each state. ABD programs are excluded.

(2) Represents the acute care business under Bridgeway Health Solutions.

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

(4) We began membership operations in Massachusetts in July 2009.

In addition, in November 2009, the Mississippi Division of Medicaid selected Centene as one of two Coordinated Care Organizations to participate in the Mississippi Coordinated Access Network, a coordinated care program for Mississippi Medicaid beneficiaries. We are continuing to work with the Division to execute a contract in which we will serve eligible members throughout the state, as Magnolia Health Plan, and expect to execute the contract and begin managing care for Supplemental Security Income (SSI) members in Mississippi in 2010.

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

Our health plans facilitate access to healthcare services for our members primarily through contracts with our providers. For each of our service areas, we establish a provider network consisting of primary and specialty care physicians, hospitals and ancillary providers. Our contracts with primary and specialty care physicians and hospitals usually are for one to two-year periods and renew automatically for successive one-year terms, but generally are subject to termination by either party upon 90 to 120 days prior written notice. As of September 30, 2009, the health plans we operated contracted with the following number of physicians and hospitals:

	Primary Care Physicians	Specialty Care Physicians	Hospitals
Arizona	235	1,748	5
Florida	764	1,832	56
Georgia	2,935	9,333	120
Indiana	1,018	3,683	87
Massachusetts	550	2,973	17
Ohio	2,326	9,105	139
South Carolina	1,030	2,374	35
Texas	8,091	20,080	379
Wisconsin	2,098	5,730	66
Total	19,047	56,858	904

Where appropriate, our health plans contract with our specialty services organizations to provide services and programs such as behavioral health, health management, managed vision, nurse triage, pharmacy benefit management,

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

Behavioral Health. Cenpatico Behavioral Health, or Cenpatico, manages behavioral healthcare for members via a contracted network of providers. We acquired Cenpatico in 2003.

Table of Contents

Individual Health Insurance. Our individual health insurance company, Celtic, is a national healthcare provider licensed in 49 states offering high-quality, affordable health insurance to individual customers and their families. We acquired Celtic in 2008.

Life and Health Management. Nurtur Health specializes in implementing life and health management programs that encourage healthy behaviors, promote healthier workplaces, improve productivity and reduce healthcare costs. Nurtur Health was formed in December 2007 through the combination of three entities we acquired from July 2005 through November 2007.

Long-term Care and Acute Care. Bridgeway Health Solutions, or Bridgeway, provides long-term care services to the elderly and people with disabilities on ABD that meet income and resources requirements and who are at risk of being or are institutionalized. Bridgeway commenced long-term care operations in October 2006. Bridgeway also provides acute care services, which commenced in October 2008.

Managed Vision. OptiCare manages vision benefits for members through a contracted network of providers. We acquired the managed vision business of OptiCare Health Systems, Inc. in July 2006.

Telehealth Services. NurseWise and Nurse Response provide a toll-free nurse triage line 24 hours per day, 7 days per week, 52 weeks per year. NurseWise commenced operations in 1998.

Pharmacy Benefits Management. US Script is a pharmacy benefits manager that administers pharmacy benefits and processes pharmacy claims via its proprietary claims processing software. We acquired US Script in January 2006.

When necessary, we also contract with third-party providers on a negotiated fee arrangement for physical therapy, home healthcare, diagnostic laboratory tests, x-ray examinations, ambulance services and durable medical equipment. Additionally, we contract with dental vendors in markets where routine dental care is a covered benefit.

INDUSTRY

We provide our services to organizations and individuals primarily through Medicaid, CHIP, Foster Care and ABD programs. The federal Centers for Medicare and Medicaid Services, or CMS, estimated the total Medicaid market was approximately $329 billion in 2007, and estimate the market will grow to $800 billion by 2018. According to the most recent information provided by the Kaiser Commission on Medicaid and the Uninsured, Medicaid spending increased by 5.3% in fiscal 2008 and states appropriated an increase of 5.8% for Medicaid in fiscal 2009 budgets.

Established in 1965, Medicaid is the largest publicly funded program in the United States, and provides health insurance to low-income families and individuals with disabilities. Authorized by Title XIX of the Social Security Act, Medicaid is an entitlement program funded jointly by the federal and state governments and administered by the states. The majority of funding is provided at the federal level. Each state establishes its own eligibility standards, benefit packages, payment rates and program administration within federal standards. As a result, there are 56 Medicaid programs one for each U.S. state, each U.S. territory and the District of Columbia. Many states have selected Medicaid managed care as a means of delivering quality healthcare and controlling costs, including states that automatically enroll Medicaid recipients who do not select a health plan. We refer to these states as mandated managed care states. Eligibility is based on a combination of household income and assets, often determined by an income level relative to the federal poverty level. Historically, children have represented the largest eligibility group.

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

Table of Contents

The Balanced Budget Act of 1997 created CHIP 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 CHIP programs. CHIP is the single largest expansion of health insurance coverage for children since the enactment of Medicaid. Costs related to the largest eligibility group, children, are primarily composed of pediatrics and family care. These costs tend to be more predictable than other healthcare issues which predominantly affect the adult population.

A portion of Medicaid beneficiaries are dual eligibles, low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. According to CMS, there were approximately eight million dual eligible enrollees in 2008. These dual eligibles may receive assistance from Medicaid for Medicaid benefits, such as nursing home care and/or assistance with Medicare premiums and cost sharing. Dual eligibles also use more services due to their tendency to have more chronic health issues. We serve dual eligibles through our ABD, long-term care programs, and Special Needs Plans.

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

Since the early 1980s, increasing healthcare costs, combined with significant growth in the number of Medicaid recipients, have led many states to establish Medicaid managed care initiatives. Additionally, a number of states are designing programs to cover the rising number of uninsured Americans. The US Census Bureau estimated there were 46.3 million Americans in 2008 that lacked health insurance. Continued pressure on states Medicaid budgets should cause public policy to recognize the value of managed care as a means of delivering quality healthcare and effectively controlling costs. A growing number of states have mandated that their Medicaid recipients enroll in managed care plans. Other states are considering moving to a mandated managed care approach. As a result, a significant market opportunity exists for managed care organizations with operations and programs focused on the distinct socio-economic, cultural and healthcare needs of the uninsured population and the Medicaid, CHIP, Foster Care and ABD populations. We believe our approach and strategy enable us to be a growing participant in this market.

OUR COMPETITIVE STRENGTHS

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

Strong Historic Operating Performance. We have increased revenues as we have grown in existing markets, expanded into new markets and broadened our product offerings. We entered the Wisconsin market in 1984, the Indiana market in 1995, the Texas market in 1999, the Arizona market in 2003, the Ohio market in 2004, the Georgia market in 2006, the South Carolina market in 2007 and the Florida and Massachusetts markets in 2009. We have increased our membership through participation in new programs in existing states. For example, in 2008, we began operations in the Texas Foster Care program and began serving Acute Care members in the Yavapai county of Arizona. We have also increased membership by acquiring Medicaid businesses, contracts and other related assets from competitors in existing markets, most recently in Florida and South Carolina in 2009. Our at-risk managed care membership totaled approximately 1.4 million as of September 30, 2009. For the year ended December 31, 2008, we had revenues of $3.4 billion, representing a 40% Compound Annual Growth Rate, or CAGR, since the year ended December 31, 2004. We generated total cash flow from

operations of $222.0 million and net earnings from continuing operations of $84.2 million for the year ended December 31, 2008.

Table of Contents

Medicaid Expertise. Over the last 25 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, CHIP, Foster Care and ABD and expand these types of benefits offered. Our approach is to accomplish this while maintaining adequate levels of provider compensation and protecting our profitability.

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 and to address chronic illnesses commonly affecting Medicaid eligible individuals. In addition to our Medicaid and Medicaid-related managed care services, our service offerings include behavioral health, individual health insurance, life and health management, long-term care programs, managed vision, telehealth and pharmacy benefits management. Through the utilization of a multi-business line approach, we are able to improve quality of care, improve outcomes and diversify our revenues and help control our medical costs.

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

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

Table of Contents

OUR BUSINESS STRATEGY

Our objective is to become the leading multi-line healthcare enterprise focusing on the uninsured population and state funded healthcare initiatives. We intend to achieve this objective by implementing the following key components of our strategy:

Increase Penetration of Existing State Markets. We seek to continue to increase our Medicaid membership in states in which we currently operate through alliances with key providers, outreach efforts, development and implementation of community-specific products and acquisitions. In 2006, we were awarded two regions in connection with Ohio s statewide restructuring of its Medicaid managed care program, expanding the number of counties we serve from three to 27. We also were awarded a Medicaid ABD contract in Ohio. In Texas, we expanded our operations to the Corpus Christi market in 2006, began managing care for ABD recipients in February 2007 and began operations in the Foster Care program in April 2008. In Arizona, we began serving members within a long-term care plan in 2006 and within an acute care plan in 2008. In 2008, we began serving Medicare members within Special Needs Plans in Arizona, Ohio, Texas and Wisconsin. We may also increase membership by acquiring Medicaid businesses, contracts and other related assets from our competitors in our existing markets or by enlisting additional providers. For example, in 2009, we acquired certain Medicaid-related assets in Florida and South Carolina.

Diversify Business Lines. We seek to broaden our business lines into areas that complement our existing business to enable us to grow and diversify our revenue. We are constantly evaluating new opportunities for expansion both domestically and abroad. For instance, in July 2008, we completed the acquisition of Celtic Insurance Company, or Celtic, a national individual health insurance provider, in October 2006, we commenced operations under our managed care program contracts to provide long-term care services in Arizona, and in January 2006, we completed the acquisition of US Script, a pharmacy benefits manager. We are also considering other premium based or fee-for-service lines of business that would provide additional diversity. We employ a disciplined acquisition strategy that is based on defined criteria including internal rate of return, accretion to earnings per share, market leadership and compatibility with our information systems. We engage our executives in the relevant operational units or functional areas to ensure consistency between the diligence and integration process.

Address Emerging State Needs. We work to assist the states in which we operate in addressing the operating challenges they face. We seek to assist the states in balancing premium rates, benefit levels, member eligibility, policies and practices, and provider compensation. For example, in 2008, we began operating under a contract with the Texas Health and Human Services Commission for Comprehensive Health Care for Children in Foster Care, a new statewide program providing managed care services to participants in the Texas Foster Care program. By helping states structure an appropriate level and range of Medicaid, CHIP and specialty services, we seek to ensure that we are able to continue to provide those services on terms that achieve targeted gross margins, provide an acceptable return and grow our business.

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

Georgia. In 2010, we expect to begin managing care for SSI members in Mississippi. In addition, we focus our attention on states converting to a full-risk, managed care model. For example, in 2007, we entered the South Carolina market and we participated in the state s conversion to at-risk managed care. In February 2009, we began managed care operations in Florida through conversion of members in certain counties from Access Health Solutions to at-risk managed care in Sunshine State Health Plan, through our new state contract. In July 2009, we began operating under our contract in Massachusetts to

Table of Contents

manage health care services for the Central, Northern, Boston and Southern regions operating as CeltiCare Health Plan of Massachusetts.

Leverage Established Infrastructure to Enhance Operating Efficiencies. We intend to continue to invest in infrastructure to further drive efficiencies in operations and to add functionality to improve the service provided to members and other organizations at a low cost. Our centralized functions enable us to add members and markets quickly and economically.

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

RECENT DEVELOPMENTS

In November 2009, the Mississippi Division of Medicaid selected Centene as one of two Coordinated Care Organizations to participate in the Mississippi Coordinated Access Network, a coordinated care program for Mississippi Medicaid beneficiaries. We are continuing to work with the Division to execute a contract in which we will serve eligible members throughout the state, as Magnolia Health Plan, and expect to execute the contract and begin managing care for SSI members in Mississippi in 2010.

We expect the following factors will increase our health benefits ratio, or HBR, in 2010:

Premium rate changes lower than historical experience, as a result of the pressure of current economic conditions on state budgets

The removal of pharmacy coverage from the services covered by medicaid managed care entities in Indiana and Ohio.

Membership mix changes, particularly a greater proportion of ABD members which historically have a higher HBR.

We expect the impact of these factors on HBR will be partially offset by a decrease in the ratio of general and administrative expenses to premium and service revenues.

In addition, our business is subject to a number of risks which you should be aware of before making an investment decision. See Risk Factors in this prospectus supplement. For example:

if any of our state contracts are terminated or not renewed, our business will suffer;

the pending health care reform legislation could harm our business;

changes in healthcare law and benefits may reduce our profitability; and

failure to effectively manage our medical costs or related administrative costs or uncontrollable epidemic or pandemic would reduce our profitability.

ADDITIONAL INFORMATION

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

Table of Contents

THE OFFERING

For a description of our common stock, see Description of Capital Stock in the accompanying prospectus.

Common stock offered by us	5,000,000 shares.
Shares outstanding after this offering	48,221,757 shares.[1]
Overallotment option	We have granted the underwriters an option to purchase from us within 30 days of the date of this prospectus supplement up to an additional 750,000 shares of common stock solely to cover overallotments, if any.
Use of proceeds	The net proceeds of this offering are estimated to be approximately $90.8 million (approximately $104.6 million if the underwriters overallotment option is exercised in full) after deducting the underwriting discount and estimated expenses of this offering. We intend to use the net proceeds: to repay the outstanding indebtedness under our $300,000,000 revolving credit loan facility ($86.0 million as of September 30, 2009), which we use for working capital and other general corporate purposes, and which terminates on September 21, 2011. Interest accrues on outstanding amounts under the facility at a rate between 0.75% and 1.75% plus LIBOR, at a rate between 0.5% and 0.75% plus the Federal Funds Rate, or at a rate between 0% and 0.25% plus the Prime Rate. Our weighted average interest rate under the facility at September 30, 2009 was 1.62%; and for general corporate purposes, which may include the repayment of indebtedness, funding for acquisitions, capital expenditures, additions to working capital and to meet statutory capital requirements in new or existing states.
Risk factors	See Risk Factors and other information included or incorporated by reference in this prospectus supplement and the accompanying prospectus for a discussion of factors you should carefully consider before deciding to invest in our common stock.
Conflicts of interest	Affiliates of certain of the underwriters are lenders and/or agents under the revolving credit facility. As described above, we intend to use proceeds from this offering for repayment of the revolving credit facility. Because at least 5% of the proceeds of this offering, not including underwriting compensation, may be received by one or more of the underwriters in this offering or by one of their affiliates, this offering is being conducted in compliance with NASD Rule 2720(a)(1), as administered by the Financial Industry Regulatory Authority (FINRA). Pursuant to that rule, the appointment of a qualified independent underwriter is not necessary in

	connection with this offering, as the offering is of a class of equity securities for which a bona fide public market, as defined by FINRA, exists. See Underwriting Conflicts of Interest in this prospectus supplement.
New York Stock Exchange symbol	CNC

[1] The number of shares of common stock to be outstanding after this offering as shown above is based on 43,221,757 shares of our common stock outstanding, net of 2,414,010 shares held in treasury, as of January 15, 2010. Unless expressly stated otherwise, the information set forth above and throughout this prospectus supplement assumes no exercise of the underwriters overallotment option. See Underwriting.

Table of Contents

SUMMARY CONSOLIDATED FINANCIAL INFORMATION

The following selected consolidated financial data should be read in conjunction with the consolidated financial statements and related notes, Item 2. Management s Discussion and Analysis of Financial Condition and Results of Operations included in our Quarterly Report on Form 10-Q for the period ended September 30, 2009 and Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations included in our Annual Report on Form 10-K for the year ended December 31, 2008. The assets, liabilities and results of operations of FirstGuard and University Health Plans have been classified as discontinued operations for all periods presented.

	Nine Months Ended September 30,		Years Ended December 31,		
	2009	2008	2008	2007	2006
	($ in thousands, except member data)				
	(Unaudited)				
Statement of Operations Data:					