HealthSpring, Inc.
Form 424B4
February 06, 2006

Table of Contents

Filed Pursuant to Rule 424(b)(4)
Registration No. 333-128939
Registration No. 333-131492

18,800,000 Shares
Common Stock

This is an initial public offering of shares of common stock of HealthSpring, Inc.

HealthSpring, Inc. is offering 10,600,000 of the shares to be sold in the offering. The selling stockholders identified in this prospectus are offering an additional 8,200,000 shares. HealthSpring, Inc. will not receive any of the proceeds from the sale of shares being sold by the selling stockholders.

Prior to this offering, there has been no public market for the common stock. The common stock has been approved for listing on the New York Stock Exchange under the symbol HS.

See Risk Factors beginning on page 8 to read about factors you should consider before buying shares of the common stock.

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

	Per Share	Total
Initial public offering price	$ 19.50	$ 366,600,000
Underwriting discount	$ 1.2675	$ 23,829,000
Proceeds, before expenses, to HealthSpring, Inc.	$ 18.2325	$ 193,264,500
Proceeds, before expenses, to the selling stockholders	$ 18.2325	$ 149,506,500

To the extent that the underwriters sell more than 18,800,000 shares of common stock, the underwriters have the option to purchase up to an additional 2,820,000 shares from the selling stockholders at the initial public offering price less the underwriting discount.

The underwriters expect to deliver the shares against payment in New York, New York, on February 8, 2006.

Joint Bookrunning Managers

Goldman, Sachs & Co. **Citigroup** **UBS Investment Bank**

Lehman Brothers **CIBC World Markets**

Raymond James **Avondale Partners**

Prospectus dated February 2, 2006.

Table of Contents

PROSPECTUS SUMMARY

The following prospectus summary does not contain all information that is important to you and is qualified in its entirety by, and should be read in conjunction with, the more detailed information and our financial statements and the related notes appearing elsewhere in this prospectus. This summary highlights what we believe is the most important information about HealthSpring, Inc. and the offering. The terms HealthSpring, company, we, us and our as used in this prospectus refer to our predecessor, NewQuest, LLC, for periods prior to March 1, 2005 and to HealthSpring, Inc. for periods after March 1, 2005, together in each case with our consolidated subsidiaries unless the context otherwise requires.

Overview

We believe we are one of the largest managed care organizations in the United States whose primary focus is the Medicare Advantage market. Pursuant to the Medicare Advantage program (formerly known as Medicare+Choice), Medicare beneficiaries receive healthcare benefits through a managed care health plan. Our concentration on Medicare Advantage provides us with opportunities to understand the complexities of the Medicare program, design competitive products, manage medical costs, and offer high quality healthcare benefits to Medicare beneficiaries in our local service areas. Our Medicare Advantage experience also allows us to build collaborative and mutually beneficial relationships with healthcare providers, including comprehensive networks of hospitals and physicians, that are experienced in managing Medicare populations. For the combined nine month period ended September 30, 2005 and the year ended December 31, 2004, Medicare premiums accounted for approximately 81.5% and 72.4%, respectively, of our total revenue, and as of December 31, 2005 our Medicare Advantage plans had over 100,200 members.

Largely as a result of changes to the Medicare program pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003, or MMA, the Congressional Budget Office expects Medicare expenditures, without taking into account the impact of the new Medicare prescription drug benefit, will rise at a compounded annual growth rate of 9.3% over 10 years, from approximately $297 billion in 2004 to approximately $722 billion in 2014. We believe that the rise in Medicare expenditures, coupled with increased reimbursements to Medicare Advantage plans, will allow Medicare Advantage plans to offer benefits that are superior to the current Medicare fee-for- service program, which should result in increased Medicare Advantage penetration rates on a national level. Medicare Advantage penetration, as a percentage of eligible Medicare beneficiaries, was approximately 12% nationwide in 2004 as compared to nationwide commercial and Medicaid managed care penetration of approximately 91% and 60%, respectively, in 2004.

Our historical operations are in areas where there have been few or no competing Medicare Advantage plans. National Medicare Advantage penetration varies widely because of various factors, including infrastructure and provider accessibility. Our service areas in particular are underpenetrated in terms of the percentage of Medicare beneficiaries enrolled in Medicare Advantage plans. Our Medicare Advantage plans currently operate in Tennessee, Texas, Alabama, Illinois, and Mississippi. We also utilize our infrastructure and provider networks in Alabama and Tennessee to offer commercial health plans to individuals and employer groups.

We commenced operations in September 2000 when our predecessor purchased an interest in an unprofitable health maintenance organization, or HMO, operating in the Nashville, Tennessee area. We restored that HMO to profitability in 2001 and have grown from servicing approximately 8,000 Medicare members in five Tennessee counties in late 2000 to serving over 100,200 Medicare members in 105 counties in five states as of December 31, 2005. We have grown our Medicare membership primarily by internal growth through expansion of our membership base and service areas. Including the initial Tennessee purchase, we have completed three acquisitions that accounted for the addition of approximately 18,000 members.

Table of Contents

The Medicare Program and Medicare Advantage

General. Medicare is the health insurance program for retired United States citizens aged 65 and older, qualifying disabled persons, and persons suffering from end-stage renal disease. Medicare is funded by the federal government and administered by the Centers for Medicare and Medicaid Services, or CMS. The Medicare eligible population is large and growing. During 2004, approximately 41.7 million people, or approximately 14% of the United States population, were enrolled in Medicare according to CMS. The Henry J. Kaiser Family Foundation estimates that the number of Medicare enrollees will increase to 43.1 million in 2006, 46 million by 2010, 61 million by 2020, and 78 million by 2030. The Congressional Budget Office expects Medicare expenditures, without taking into account the new prescription drug benefit, will rise at a compounded annual growth rate of 9.3%, from approximately $297 billion in 2004 to approximately $722 billion in 2014.

Medicare is offered to eligible beneficiaries on a fee-for-service basis or through a managed care plan that has contracted with CMS pursuant to the Medicare Advantage program. In 2005, nationwide Medicare Advantage penetration, expressed as a percentage of total Medicare eligible beneficiaries who belong to a Medicare Advantage plan, is approximately 13%. Medicare Advantage penetration is anticipated to grow to almost 30% by 2013, according to the Henry J. Kaiser Family Foundation. We believe that the projected favorable Medicare Advantage enrollment trends and the reforms proposed by the MMA will have a positive impact on our Medicare Advantage plans.

New Prescription Drug Benefit. As of January 1, 2006, every Medicare recipient was able to select a prescription drug plan through Medicare Part D. Each Medicare Advantage plan is required to offer a Part D prescription drug plan as part of its benefits. Medicare Advantage plan enrollees may pay a monthly premium for this Medicare Part D prescription drug benefit, or MA-PD, while fee-for service beneficiaries are able to purchase a stand-alone prescription drug plan, or PDP, from a list of CMS-approved PDPs available in their area. In addition, certain beneficiaries eligible for both Medicare and Medicaid, or dual-eligible beneficiaries, who have not enrolled in a Medicare Advantage plan or PDP have been automatically enrolled by CMS with approved PDPs in their region. The cost of the Medicare Part D prescription drug benefit will be largely subsidized by the federal government.

We currently offer prescription drug benefits through our Medicare Advantage plans, in the form of MA-PD benefits, and stand-alone PDPs in each of our service areas. We believe our experience in managing prescription drug benefits as part of our existing health plans positions us well to manage the new Medicare Part D prescription drug benefit. We commenced marketing our PDPs in October 2005 and began enrolling members as of November 15, 2005. We expect a substantial increase in our Medicare membership in 2006 attributable to new enrollment in our stand-alone PDPs. As of January 1, 2006, we had approximately 90,000 beneficiaries enrolled in our stand-alone PDPs, substantially all of whom are auto-enrolled dual-eligible beneficiaries.

Our Competitive Advantages

We believe the following are our key competitive advantages:

Focus on Medicare Advantage. We are focused on designing and operating Medicare Advantage health plans tailored for each of our local service areas.

Leading Presence in Attractive, Underpenetrated Markets. We have a significant market position in our established service areas and in many areas we are the market leader in terms of the number of members. Medicare Advantage penetration varies widely across the country because of various factors, including infrastructure and provider accessibility, and our service areas in particular are underpenetrated by other Medicare Advantage plans, providing significant opportunities for continued membership growth within those areas.

Table of Contents

Effective Medical Management. Our medical management efforts are designed primarily for the Medicare Advantage program. For the combined nine months ended September 30, 2005, our Medicare medical loss ratio, or MLR, was 78.4%, and our Medicare MLR for each of the years ended December 31, 2003 and 2004 was 78.1%. We believe our ability to predict and manage our medical expenses is the result of our:

- data-driven, analytical focus on operations;
- ability to leverage our experience in managing provider relationships and organizations to create collaborative and mutually beneficial provider partnerships with incentives designed to encourage our providers to deliver a level of care that promotes member wellness, reduces avoidable catastrophic outcomes, and improves clinical and financial results;
- focus on efficiently treating chronically ill members through comprehensive internal and outsourced disease management programs; and
- comprehensive case management programs designed to provide more efficient and effective use of healthcare services by our members generally.

Scalable Operating Structure. We believe our combination of centralized administrative functions and local market focus, including localized medical management programs and on-site personnel at facility locations, gives us an advantage over competitors who have standardized and centralized many or all of these operating and member services functions.

Experienced Management Team. Our management team has expertise in the Medicare Advantage and independent physician association management segments of the managed care industry. Our present operations team has focused primarily on the operation of Medicare managed care plans since 2000.

Our Growth Strategy

We intend to grow our business by focusing on the Medicare Advantage market. Key elements of our growth strategy are to:

- attract fee-for-service beneficiaries to our Medicare Advantage plans by designing health plans attractive to seniors both in terms of benefits, such as general wellness, fitness, and transportation programs, and cost-savings over traditional fee-for-service Medicare, and by educating the eligible population in our service areas about the benefits of Medicare Advantage plans over traditional fee-for-service Medicare;
- increase membership within existing service areas;
- expand to new service areas through leverage of existing operations;
- pursue dual-eligible beneficiaries;
- provide prescription drug plan coverage; and
- pursue acquisitions opportunistically.

Business Risks

Through the operation of our business and in connection with this offering, we are subject to certain risks related to our industry, our business and this transaction. The risks set forth under the section entitled Risk Factors beginning on page 8 of this prospectus reflect risks and uncertainties that could significantly and adversely affect our business, prospects, financial condition, operating results, and growth strategy. In summary, significant risks related to our business include:

- reduction in funding for Medicare programs;

regulatory requirements or new legislation that could impair our operations and profitability;

termination or nonrenewal of our Medicare contracts;

Table of Contents

failure to effectively manage our medical costs;

disruption in our provider networks; and

competition from other health plan providers.

In connection with your investment decision, you should review the section of this prospectus entitled Risk Factors.

Recent Developments

Although combined consolidated financial statements are not yet available for the year ended December 31, 2005, the information below summarizes certain of our preliminary financial results and operating statistics as of and for the year ended December 31, 2005 and the eleven month period ended November 30, 2005.

Our Medicare Advantage membership increased to over 100,200 members at December 31, 2005, as compared to 63,792 members at December 31, 2004. We estimate that combined consolidated revenue for the year ended December 31, 2005 will range between $850 million and $860 million, as compared to $599.4 million for NewQuest, LLC, our predecessor, for the year ended December 31, 2004.

Total revenue for the combined eleven months ended November 30, 2005 was approximately $772.8 million as compared to approximately $545.3 million for our predecessor for the eleven months ended November 30, 2004. Total premium revenue was approximately $750.4 million for the 2005 combined eleven month period, of which approximately $634.3 million, or 84.5%, was attributable to Medicare premiums. Net income, before preferred dividends, was $28.0 million for the 2005 combined eleven month period as compared to $45.1 million for our predecessor for the eleven months ended November 30, 2004. Net income, before preferred dividends, in the 2005 eleven month period has been reduced by the following items attributable to the company s recapitalization on March 1, 2005, which was accounted for under the purchase method: $8.6 million of transaction expenses; $4.3 million for amortization of intangibles; and $13.0 million of interest expense.

This financial and operating data is unaudited and is subject to revision based on the completion of the accounting and financial reporting processes necessary to finalize our financial statements as of and for the year ended December 31, 2005. We cannot assure you that, upon completion of the audit of our financial statements as of and for the year ended December 31, 2005, we will not report results materially different than those set forth above. This information should be read in conjunction with the financial statements and the related notes and Management s Discussion and Analysis of Financial Condition and Results of Operations for prior periods included elsewhere in this prospectus.

Corporate History and Information

We were incorporated in October 2004 in connection with the leveraged recapitalization of our predecessor, NewQuest, LLC, by HealthSpring, Inc. and certain investment funds affiliated with GTCR Golder Rauner II, L.L.C., which we collectively refer to in this prospectus as GTCR or the GTCR Funds, together with management, our existing equityholders, lenders and other investors. Pursuant to the recapitalization, the GTCR Funds obtained a controlling interest in us. The recapitalization, which was accounted for using the purchase method, is more fully described below in the sections entitled Recapitalization and Certain Relationships and Related Transactions.

Our corporate headquarters are located at 44 Vantage Way, Suite 300, Nashville, Tennessee 37228, and our telephone number is (615) 291-7000. Our corporate website address is www.myhealthspring.com. Information contained on our website is not incorporated by reference into this prospectus and we do not intend the information on or linked to our website to constitute part of this prospectus.

The HealthSpring name appearing in this prospectus is our registered service mark.

Table of Contents

The Offering

Common stock offered by us	10,6000,000 shares
Common stock offered by the selling stockholders	8,200,000 shares
Over-allotment option by the selling stockholders	2,820,000 shares
Common stock to be outstanding after this offering	57,289,549 shares
Use of proceeds	We will use the net proceeds from this offering, together with available cash, to repay all of our outstanding indebtedness. We will not receive any of the proceeds from the sale of shares of common stock by the selling stockholders in this offering. See Use of Proceeds.
New York Stock Exchange symbol	HS

The number of shares of our common stock to be outstanding after this offering excludes:

195,000 shares of common stock issuable upon exercise of options issued under our 2005 stock option plan, at a weighted average exercise price of $2.50 per share, none of which options are currently exercisable;

2,065,500 shares of common stock issuable upon exercise of options awarded, effective as of the completion of this offering, under our 2006 equity incentive plan, at an exercise price equal to the initial public offering price; and

4,172,000 shares of common stock reserved for future issuance under our 2006 equity incentive plan.

Except as otherwise noted, all information in this prospectus:

assumes no exercise of the underwriters over-allotment option;

gives effect to the conversion of all outstanding shares of our preferred stock and accrued and unpaid dividends thereon through February 7, 2006 into 12,552,905 shares of our common stock based upon the initial public offering price;

gives effect to the exchange of all membership units of one of our subsidiaries, Texas HealthSpring, LLC, that are not owned by us for 2,040,194 shares of our common stock based upon the initial public offering price;

gives effect to our second amended and restated bylaws and amended and restated certificate of incorporation, which will be effective immediately prior to the completion of this offering; and

gives effect to a one-for-two reverse common stock split effective immediately prior to the completion of this offering.

Table of Contents

Summary Consolidated Financial Data and Other Information

The following table presents our summary consolidated financial data and other information. This information should be read in conjunction with the financial statements and the related notes and Management s Discussion and Analysis of Financial Condition and Results of Operations included elsewhere in this prospectus.

	Predecessor				HealthSpring, Inc.		
	Year Ended December 31,			Nine Months Ended	Period from January 1, 2005 to February 28,	Period from March 1, 2005 to	Combined Nine Months Ended
	2002	2003(1)	2004(2)	September 30, 2004	2005(3)	September 30, 2005(3)	September 30, 2005(4)
	(Dollars in thousands, except share and unit data)						
Statement of Income Data:							
Revenue:							
Premium:							
Medicare premiums	$ (5)	$ 240,037	$ 433,729	$ 314,358	$ 94,764	$ 403,212	$ 497,976
Commercial premiums	(5)	120,877	146,318	111,499	20,704	73,857	94,561
Total premiums	24,939	360,914	580,047	425,857	115,468	477,069	592,537
Fee revenue	1,099	11,054	17,919	13,508	3,461	12,018	15,479
Investment income	78	695	1,449	821	461	2,224	2,685
Total revenue	26,116	372,663	599,415	440,186	119,390	491,311	610,701
Expenses:							
Medical expense:							
Medicare expense	(5)	187,368	338,632	243,646	74,531	315,776	390,307
Commercial expense	(5)	104,164	124,743	95,422	16,312	65,437	81,749
Total medical expense	12,631	291,532	463,375	339,068	90,843	381,213	472,056
	11,133	50,576	68,868	48,953	14,667	61,577	76,244

Selling, general and administrative							
Transaction expense					6,941	1,700	8,641
Phantom stock compensation			24,200				
Depreciation and amortization	275	2,361	3,210	2,352	315	4,782	5,097
Interest	25	256	214	158	42	10,150	10,192
Total operating expenses	24,064	344,725	559,867	390,531	112,808	459,422	572,230
Equity in earnings of unconsolidated affiliates	4,148	2,058	234	192		30	30
Option amendment gain	4,170						
Income before minority interest and income taxes	10,370	29,996	39,782	49,847	6,582	31,919	38,501
Minority interest	(1,315)	(5,519)	(6,272)	(5,098)	(1,248)	(1,218)	(2,466)
Income before income taxes	9,055	24,477	33,510	44,749	5,334	30,701	36,035
Income tax expense	363	5,417	9,193	7,076	2,628	12,139	14,767
Net income before preferred dividends	8,692	19,060	24,317	37,673	2,706	18,562	21,268
Preferred dividends						10,759	10,759
Net income available to members or	$ 8,692	$ 19,060	$ 24,317	$ 37,673	$ 2,706	$ 7,803	$ 10,509

common stockholders							
Net income per unit basic and diluted	$ 2.13	$ 4.67	$ 5.31	$ 8.23	$ 0.55		
Weighted average units outstanding basic and diluted	4,078,176	4,078,176	4,578,176	4,578,176	4,884,176		
Net income per common share available to common stockholders:							
Basic						$	0.24
Diluted						$	0.24
Common shares outstanding:							
Basic							32,161,574
Diluted							32,161,574

Table of Contents

	Predecessor				HealthSpring, Inc.		
	Year Ended December 31,			Nine Months Ended	Period from January 1, 2005 to February 28,	Period from March 1, 2005 to	Combined Nine Months Ended
	2002	2003(1)	2004(2)	September 30, 2004	2005(3)	September 30, 2005(3)	September 30, 2005(4)
	(Dollars in thousands, except share and unit data)						
Cash Flow Data:							
Capital expenditures	$ 190	$ 3,198	$ 2,512	$ 2,558	$ 149	$ 2,026	$ 2,175
Cash provided by (used in):							
Operating activities	6,569	63,392	24,665	5,176	14,964	99,193	114,157
Investing activities	(6,123)	42,647	(34,615)	(39,207)	(5,469)	(277,399)(6)	(282,868)
Financing activities	5,748	(11,750)	(23,311)	(23,060)	(888)	328,614(6)	327,726
Balance Sheet Data (at period end):							
Cash and cash equivalents	6,806	101,095	67,834	44,004	76,441	150,408	150,408
Total assets	37,559	132,420	142,674	118,155	157,350	646,131	646,131
Total long-term debt, including current maturities	4,958	6,175	5,475	5,650	5,358	192,378	192,378
Members /stockholders equity	14,504	22,969	55,435	48,013	59,456	255,402	255,402
Operating Statistics:							
Medical loss ratio Medicare(7)	(5)	78.06%	78.07%	77.51%	78.65%	78.32%	78.38%

Medical loss ratio Commercial(7)	(5)	86.17%	85.25%	85.58%	78.79%	88.60%	86.45%
Selling, general and administrative expense ratio(8)	42.63%	13.57%	11.49%	11.12%	12.28%	12.53%	12.48%
Members Medicare(9)	33,560	47,899	63,792	59,529	69,236	93,181	93,181
Members Commercial(9)	53,605	54,280	48,380	50,857	40,523	41,937	41,937

(1) Prior to April 1, 2003, TennQuest Health Solutions, LLC, or TennQuest, owned 50% of the outstanding stock of HealthSpring Management, Inc., or HSMI. On April 1, 2003, TennQuest exercised an option to acquire an additional 33% interest in HSMI from another shareholder of HSMI. As a result of the acquisition of these shares, the company held 83% of the ownership interests in HSMI and consolidated the results of operations of HSMI s wholly-owned subsidiary HealthSpring of Tennessee, Inc., or HTI, within the company s operations for the period from April 1, 2003. Prior to April 1, 2003, the company accounted for its ownership interest in HSMI under the equity method. On December 19, 2003, HSMI and HealthSpring USA, LLC each redeemed certain of their outstanding ownership interests, which resulted in the company owning 84.8% of the outstanding ownership interests of HSMI and HealthSpring USA, LLC at December 31, 2003.

(2) On January 1, 2004, the minority members of TennQuest converted their ownership of TennQuest into 500,000 membership units in NewQuest, LLC, and on February 2, 2004 TennQuest was merged into NewQuest, LLC. Effective December 31, 2004, holders of phantom membership units in NewQuest, LLC converted their phantom units into 306,025 membership units of NewQuest, LLC. In connection with the conversion, the company recognized phantom stock compensation expense of $24.2 million.

(3) On November 10, 2004, NewQuest, LLC and its members entered into a purchase and exchange agreement with the company as part of the recapitalization. Pursuant to this agreement and a related stock purchase agreement, on March 1, 2005, the GTCR Funds and certain other persons contributed $139.7 million of cash to the company and the members of NewQuest, LLC contributed a portion of their membership units in exchange for preferred and common stock of the company. Additionally, we entered into a $165.0 million term loan, with an additional $15.0 million available pursuant to a revolving loan facility, and issued $35.0 million of subordinated notes. We used the cash contribution and borrowings to acquire the members remaining membership units in NewQuest, LLC for $295.4 million in cash. The aggregate transaction value for the recapitalization was $438.8 million, which included $5.3 million of capitalized acquisition related costs and $6.3 million of deferred financing costs. In addition, NewQuest, LLC incurred $6.9 million of transaction costs that were expensed during the two-month period ended February 28, 2005 and the company incurred $1.7 million of transaction costs that were expensed during the seven-month period ended September 30, 2005. The transactions resulted in the company recording $323.8 million in goodwill and $91.2 million in identifiable intangible assets.

(4) The combined financial information for the nine months ended September 30, 2005 includes the results of operations of NewQuest, LLC, for the period from January 1, 2005 through February 28, 2005 and the results of operations of the company for the period from March 1, 2005 through September 30, 2005. The combined financial information is for illustrative purposes only, reflects the combination of the two month period and the seven month period to provide a comparison with the comparable nine month

period in 2004, and is not presented in accordance with U.S. generally accepted accounting principles, or GAAP.

(5) Premium revenue and medical expense are reported in total only and are not separated into Medicare and commercial for 2002 as the company did not report information in this format. As a result, the company is not able to determine the Medicare and commercial medical loss ratios for 2002.

(6) A substantial portion of the cash flows for investing and financing activities for the seven-month period ended September 30, 2005 relate to the recapitalization. See Recapitalization and Management s Discussion and Analysis of Financial Condition and Results of Operations The Recapitalization.

(7) The medical loss ratio represents medical expense incurred for plan participants as a percentage of premium revenue for plan participants.

(8) The selling, general and administrative expense ratio represents selling, general and administrative expenses as a percentage of total revenue.

(9) At end of each period presented.

Table of Contents

RISK FACTORS

Any investment in our common stock involves a high degree of risk. You should consider carefully the risks and uncertainties described below, and all information contained in this prospectus, before you decide whether to purchase our common stock. The occurrence of any of the following risks or uncertainties described below could significantly and adversely affect our business, prospects, financial condition, and operating results. In any such event, the trading price of our common stock could decline and you may lose part or all of your investment.

Risks Related to Our Industry

Reductions in Funding for Medicare Programs Could Significantly Reduce Our Profitability.

Approximately 81.5% and 72.4% of our total revenue for the combined nine months ended September 30, 2005 and the year ended December 31, 2004, respectively, are premiums generated by the operation of our Medicare Advantage health plans. As a result, our revenue and profitability are dependent on government funding levels for Medicare Advantage programs. The premium rates paid to Medicare Advantage health plans like ours are established by contract, although the rates differ depending on a combination of factors, including upper payment limits established by CMS, a member s health profile and status, age, gender, county or region, benefit mix, member eligibility categories, and the plan s risk scores. Future Medicare premium rate levels may be affected by continuing government efforts to contain medical expense or other federal budgetary constraints. Changes in the Medicare program, including with respect to funding, may lead to reductions in the amount of reimbursement, elimination of coverage for certain benefits, or reductions in the number of persons enrolled in or eligible for Medicare.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 Made Changes to the Medicare Program That Will Materially Impact Our Operations and Could Reduce Our Profitability and Increase Competition for Members.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003, or MMA, substantially changed the Medicare program and will modify how we operate our Medicare Advantage business. Many of these changes are effective for 2006 and, as we have not been able to fully assess the impact of these changes, we do not know whether we will be able to operate our Medicare Advantage plans at current levels of profitability or competitively with other managed care companies. Although many of these changes are designed to benefit Medicare Advantage plans generally, certain provisions of the MMA may increase competition, create challenges for us with respect to educating our existing and potential members about the changes, and create other risks and substantial and potentially adverse uncertainties, including the following:

Increased competition could adversely affect our enrollment and results of operations:

The MMA increased reimbursement rates for Medicare Advantage plans. We believe higher reimbursement rates may increase the number of plans that participate in the Medicare program, creating additional competition that could adversely affect our enrollment and results of operations. For example, prior to the MMA, there were three Medicare Advantage plans in our Houston, Texas service area. Currently, there are five plans with Medicare Advantage members in that service area. In addition, as a result of Medicare Part D, a number of potential new competitors, such as pharmacy benefits managers and prescription drug retailers and wholesalers, have established stand-alone prescription drug plans, or PDPs, which may be competitive with some of our Medicare programs.

Managed care companies began offering various new products beginning in 2006 pursuant to the MMA, including regional preferred provider organizations, or PPOs, and private fee-for-service plans. Medicare PPOs and private fee-for-service plans allow their members more

Table of Contents

flexibility in selecting physicians than Medicare Advantage HMOs such as ours, which typically require members to coordinate with a primary care physician. The MMA has encouraged the creation of regional PPOs through various incentives, including certain risk corridors, or cost-reimbursement provisions, a stabilization fund for incentive payments, and special payments to hospitals not otherwise contracted with a Medicare Advantage plan who treat regional plan enrollees. We are currently unable to determine whether the formation of regional Medicare PPOs and private fee-for-service plans will affect our Medicare Advantage plans relative attractiveness to existing and potential Medicare members in our service areas.

The new limited annual enrollment process may adversely affect our growth and ability to market our products:

Beginning in 2006, Medicare beneficiaries generally have a more limited annual enrollment period during which they can choose to participate in a Medicare Advantage plan or receive benefits under the traditional fee-for-service Medicare program. See Business The 2003 Medicare Modernization Act Annual Enrollment and Lock-in for a description of the annual enrollment process. After the annual enrollment period, most Medicare beneficiaries will not be permitted to change their Medicare benefits. The new annual enrollment process and subsequent lock-in provisions of the MMA may adversely affect our growth as it will limit our ability to enter new service areas and market to or enroll new members in our established service areas outside of the annual enrollment period.

The limited annual enrollment period may make it difficult to retain an adequate sales force:

As a result of the limited annual enrollment period and the subsequent lock-in provisions of the MMA, our sales force, including our independent sales brokers and agents, may be limited in their ability to market our products year-round. Our agents rely substantially on sales commissions for their income. Given the limited annual sales window, it may become more difficult to find agents to market and promote our products. The annual enrollment window may also make hiring full-time sales employees impracticable, which could increase our already substantial reliance on outside agents. Accordingly, we may not be able to retain an adequate sales force to support our growth strategy. As our members are primarily enrolled through in-person sales calls, a reduction in our sales force may adversely affect our future enrollment, including our expansion efforts, and, accordingly, adversely and materially affect our profitability and results of operations.

The new competitive bidding process may adversely affect our profitability:

As of January 1, 2006, the payments for local and regional Medicare Advantage plans are based on a competitive bidding process that may decrease the amount of premiums paid to us or cause us to increase the benefits we offer without a corresponding increase in premiums. As a result of the competitive bidding process, in order to maintain our current level of profitability we may in the future be required to reduce benefits or charge our members an additional premium, either of which could make our health plans less attractive to members and adversely affect our membership.

We may be unable to provide the new Medicare Part D benefit profitably:

Managed care companies that offer Medicare Advantage plans were required to offer prescription drug benefits beginning January 1, 2006 as part of their Medicare Advantage plans. Such combined managed care plans offering drug benefits are, under the new law, called MA-PDs. It is not known at this time whether the governmental payments will be adequate to cover our actual costs for these new MA-PD benefits or, in light of our

Table of Contents

inexperience with this program, whether we will be able to profitably or competitively manage our MA-PDs.

Managed care companies began offering PDPs as of January 1, 2006. These PDPs provide Medicare eligible beneficiaries with an opportunity to obtain a stand-alone drug benefit without joining a Medicare Advantage plan. Some enrollees may have chosen our Medicare Advantage plan in the past rather than those of our competitors or traditional Medicare fee-for-service because of the drug benefit that we offer with our Medicare Advantage plans. We do not know at this time whether our PDP or MA-PD benefits will be as or more attractive than those of our competitors. Additionally, Medicare beneficiaries that participate in a Medicare Advantage plan that enroll in a PDP will be automatically disenrolled from their Medicare Advantage plan. Accordingly, the existence of new PDPs in our service areas could result in our members intentionally or inadvertently disenrolling from our plans and reduce our membership and profitability.

We began marketing our MA-PDs and PDPs in October 2005 and began enrolling members, effective as of January 1, 2006, on November 15, 2005. Our ability to profitably operate our MA-PDs and PDPs will depend on a number of factors, including our ability to attract members, to develop the necessary core systems and processes and to manage our medical expense related to these plans. Because required prescription drug benefits are new to Medicare and to the health insurance market generally, there is significant uncertainty of the potential market size, consumer demand, and related MLR. Accordingly, we do not know whether we will be able to operate our MA-PDs or PDPs profitably or competitively, and our failure to do so could have an adverse effect on our results of operations.

The MMA provides for risk corridors that are expected to limit to some extent the losses MA-PDs or PDPs would incur if their costs turned out to be higher than those in the per member per month, or PMPM, bids submitted to CMS in excess of certain specified ranges. For example, for 2006 and 2007 drug plans will bear all gains and losses up to 2.5% of their expected costs, but will be reimbursed for 75% of the losses between 2.5% and 5%, and 80% of losses in excess of 5%. It is anticipated that the initial risk corridors in 2006 and 2007 will provide more protection against excess losses than will be available beginning in 2008 and future years as the thresholds increase and the reimbursement percentages decrease. In addition, we expect there will be a delay in obtaining reimbursement from CMS for reimbursable losses pursuant to the risk corridors. For example, if we incur reimbursable losses in 2006, we would not be reimbursed by CMS until 2007. In that event, we expect there would be a negative impact on our cash flows and financial condition as a result of being required to finance excess losses until we are reimbursed. In addition, as the risk corridors are designed to be symmetrical, a plan whose actual costs fall below their expected costs would be required to reimburse CMS based on a similar methodology as set forth above. Furthermore, reconciliation payments for estimated upfront federal reinsurance payments, or, in some cases, the entire amount of the reinsurance payments, for Medicare beneficiaries who reach the drug benefit s catastrophic threshold are made retroactively on an annual basis, which could expose plans to upfront costs in providing the benefit. Accordingly, it may be difficult to accurately predict or report the operating results associated with our drug benefits.

CMS s Risk Adjustment Payment System and Budget Neutrality Factors Make Our Revenue and Profitability Difficult to Predict and Could Result In Material Retroactive Adjustments to Our Results of Operations.

CMS has implemented a risk adjustment payment system for Medicare health plans to improve the accuracy of payments and establish incentives for Medicare plans to enroll and treat less healthy Medicare beneficiaries. CMS is phasing-in this payment methodology with a risk adjustment model that bases a portion of the total CMS reimbursement payments on various clinical and demographic

factors including hospital inpatient diagnoses, diagnosis data from ambulatory treatment settings, including hospital outpatient facilities and physician visits, gender, age, and Medicaid eligibility. CMS requires that all managed care companies capture, collect, and submit the necessary diagnosis code information to CMS twice a year for reconciliation with CMS s internal database. As part of the phase-in, during 2003, risk adjusted payments accounted for 10% of Medicare health plan payments, with the remaining 90% being reimbursed in accordance with the traditional CMS demographic rate books. The portion of risk adjusted payments was increased to 30% in 2004, 50% in 2005, and 75% in 2006, and will increase to 100% in 2007. As a result of this process, it is difficult to predict with certainty our future revenue or profitability. In addition, our own risk scores for any period may result in favorable or unfavorable adjustments to the payments we receive from CMS and our Medicare premium revenue. There can be no assurance that our contracting physicians and hospitals will be successful in improving the accuracy of recording diagnosis code information and thereby enhancing our risk scores.

Payments to Medicare Advantage plans are also adjusted by a budget neutrality factor that was implemented in 2003 by Congress and CMS to prevent health plan payments from being reduced overall while, at the same time, directing risk adjusted payments to plans with more chronically ill enrollees. In general, this adjustment has favorably impacted payments to all Medicare Advantage plans. The President s budget for 2005 assumed the phasing out of the budget neutrality adjustments over a five year period from 2007 through 2011. On December 21, 2005, the U.S. Senate passed legislation that reduces federal funding for Medicare Advantage plans by approximately $6.2 billion over five years. Among other changes, the legislation provides for an accelerated phase-out of budget neutrality for risk adjustment of payments made to Medicare Advantage plans. The U.S. House of Representatives has passed similar legislation but must approve the final version of the Senate legislation before the legislation can go to the President for signature. These legislative changes will have the effect of reducing payments to Medicare Advantage plans in general. Consequently, our plans premiums will be reduced unless our risk scores increase. Although our risk scores have increased historically, there is no assurance that the increases will continue or, if they do, that they will be large enough to offset the elimination of this adjustment.

Our Business Activities Are Highly Regulated and New and Proposed Government Regulation or Legislative Reforms Could Increase Our Cost of Doing Business, and Reduce Our Membership, Profitability, and Liquidity.

Our health plans are subject to substantial federal and state regulation. These laws and regulations, along with the terms of our contracts and licenses, regulate how we do business, what services we offer, and how we interact with our members, providers, and the public. Healthcare laws and regulations are subject to frequent change and varying interpretations. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or the issuance of new regulations could adversely affect our business by, among other things:

- imposing additional license, registration, or capital reserve requirements;
- increasing our administrative and other costs;
- forcing us to undergo a corporate restructuring;
- increasing mandated benefits without corresponding premium increases;
- limiting our ability to engage in inter-company transactions with our affiliates and subsidiaries;
- forcing us to restructure our relationships with providers; or
- requiring us to implement additional or different programs and systems.

It is possible that future legislation and regulation and the interpretation of existing and future laws and regulations could have a material adverse effect on our ability to operate under the Medicare program and to continue to serve our members and attract new members.

Table of Contents

If We Are Required to Maintain Higher Statutory Capital Levels for Our Existing Operations or if We Are Subject to Additional Capital Reserve Requirements as We Pursue New Business Opportunities, Our Cash Flows and Liquidity May Be Adversely Affected.

Our health plans are operated through subsidiaries in various states. These subsidiaries are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, or net worth, as defined by each state. One or more of these states may raise the statutory capital level from time to time. Other states have adopted risk-based capital requirements based on guidelines adopted by the National Association of Insurance Commissioners, which tend to be, although are not necessarily, higher than existing statutory capital requirements. Currently, Texas is the only jurisdiction in which we operate that has adopted risk-based capital requirements. Regardless of whether the other states in which we operate adopt risk-based capital requirements, the state departments of insurance can require our subsidiaries to maintain minimum levels of statutory capital in excess of amounts required under the applicable state laws if they determine that maintaining additional statutory capital is in the best interests of our members. Any increases in these requirements could materially increase our reserve requirements. In addition, as we continue to expand our plan offerings in new states or pursue new business opportunities, including our strategy to offer PDPs, we may be required to maintain additional statutory capital reserves. In either case, our available funds could be materially reduced, which could harm our ability to implement our business strategy.

If State Regulators Do Not Approve Payments, Including Dividends and Other Distributions, by Our Health Plans to Us, Our Business and Growth Strategy Could Be Materially Impaired or We Could Be Required to Incur Additional Indebtedness to Fund These Strategies.

Our health plan subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions they can pay to us for purposes other than to pay income taxes related to the earnings of the health plans. These laws and regulations also limit the amount of management fees our health plan subsidiaries may pay to affiliates of our health plans, including our management subsidiaries, without prior approval of, or notification to, state regulators. The pre-approval and notice requirements vary from state to state with some states, such as Texas, generally allowing, subject to advance notice requirements, dividends to be declared, provided the HMO meets or exceeds the applicable deposit, net worth, and risk-based capital requirements. The discretion of the state regulators, if any, in approving or disapproving a dividend is not always clearly defined. Health plans that declare non-extraordinary dividends must usually provide notice to the regulators in advance of the intended distribution date. If the regulators were to deny or significantly restrict our subsidiaries requests to pay dividends to us or to pay management and other fees to the affiliates of our health plan subsidiaries, the funds available to us would be limited, which could impair our ability to implement our business and growth strategy or we could be required to incur additional indebtedness to fund these strategies.

Historically, we have not relied on dividends or other distributions from our health plans to fund a material amount of our operating cash requirements. Distributions to us by our health plans in 2004, other than those related to tax payments, totaled $438,000, all of which came from our Texas HMO following a routine 30-day notice to the Texas Department of Insurance. We did not receive any dividends or distributions from our health plans in 2005.

We Are Required to Comply With Laws Governing the Transmission, Security and Privacy of Health Information That Require Significant Compliance Costs, and Any Failure to Comply With These Laws Could Result in Material Criminal and Civil Penalties.

Regulations under the Health Insurance Portability and Accountability Act of 1996, or HIPAA, require us to comply with standards regarding the exchange of health information within our company and with third parties, including healthcare providers, business associates and our members. These regulations include standards for common healthcare transactions, including claims

Table of Contents

information, plan eligibility, and payment information; unique identifiers for providers and employers; security; privacy; and enforcement. HIPAA also provides that to the extent that state laws impose stricter privacy standards than HIPAA privacy regulations, a state seeks and receives an exception from the Department of Health and Human Services regarding certain state laws, or state laws concern certain specified areas, such state standards and laws are not preempted.

We will conduct our operations in an attempt to comply with all applicable HIPAA requirements. Given the complexity of the HIPAA regulations, the possibility that the regulations may change, and the fact that the regulations are subject to changing and, at times, conflicting interpretation, our ongoing ability to comply with the HIPAA requirements is uncertain. Furthermore, a state s ability to promulgate stricter laws, and uncertainty regarding many aspects of such state requirements, make compliance more difficult. To the extent that we submit electronic healthcare claims and payment transactions that do not comply with the electronic data transmission standards established under HIPAA, payments to us may be delayed or denied. Additionally, the costs of complying with any changes to the HIPAA regulations may have a negative impact on our operations. Sanctions for failing to comply with the HIPAA health information provisions include criminal penalties and civil sanctions, including significant monetary penalties. In addition, our failure to comply with state health information laws that may be more restrictive than the regulations issued under HIPAA could result in additional penalties.

Risks Related to Our Business

If Our Medicare Contracts Are Not Renewed or Are Terminated, Our Business Would Be Substantially Impaired.

We provide services to our Medicare eligible members through our Medicare Advantage health plans pursuant to a limited number of contracts with CMS. These contracts generally have terms of one year and must be renewed each year. Each of our contracts with CMS is terminable for cause if we breach a material provision of the contract or violate relevant laws or regulations. If we are unable to renew, or to successfully rebid or compete for any of these contracts, or if any of these contracts are terminated, our business would be materially impaired.

Because Our Premiums, Which Generate Most of Our Revenue, Are Established by Contract and Cannot Be Modified During the Contract Terms, Our Profitability Will Likely Be Reduced or We Could Cease to Be Profitable if We Are Unable to Manage Our Medical Expenses Effectively.

Substantially all of our revenue is generated by premiums consisting of monthly payments per member that are established by contracts with CMS for our Medicare Advantage plans or by contracts with our commercial customers, all of which are typically renewable on an annual basis. For the month of November 2005, our Medicare premiums across our service areas ranged from an average of $630.19 to $778.29 per member per month. If our medical expenses exceed our estimates, except in very limited circumstances or as a result of risk score adjustments for member acuity, we will be unable to increase the premiums we receive under these contracts during the then-current terms. As a result, our profitability depends, to a significant degree, on our ability to adequately predict and effectively manage our medical expenses related to the provision of healthcare services. Relatively small changes in our MLR can create significant changes in our financial results. Accordingly, the failure to adequately predict and control medical expenses and to make reasonable estimates and maintain adequate accruals for incurred but not reported, or IBNR, claims, may have a material adverse effect on our financial condition, results of operations, or cash flows.

Historically, our medical expenses as a percentage of premium revenue have fluctuated. For example, our Medicare medical expenses were 78.1% of our Medicare premium revenue in 2003

Table of Contents

and 2004 and 78.4% for the combined nine months ended September 30, 2005. Our commercial medical expenses were 86.2% of our commercial premium revenue in 2003, 85.3% in 2004, and 86.5% for the combined nine months ended September 30, 2005. Factors that may cause medical expenses to exceed our estimates include:

- an increase in the cost of healthcare services and supplies, including pharmaceuticals, whether as a result of inflation or otherwise;
- higher than expected utilization of healthcare services;
- periodic renegotiation of hospital, physician, and other provider contracts;
- changes in the demographics of our members and medical trends affecting them;
- new mandated benefits or other changes in healthcare laws, regulations, and practices;
- new treatments and technologies;
- consolidation of physician, hospital, and other provider groups;
- contractual disputes with providers, hospitals, or other service providers; and
- the occurrence of catastrophes, major epidemics, or acts of terrorism.

Because of the relatively high average age of the Medicare population, medical expenses for our Medicare Advantage plans may be particularly difficult to control. We attempt to control these costs through a variety of techniques, including capitation and other risk-sharing payment methods, collaborative relationships with primary care physicians and other providers, advance approval for hospital services and referral requirements, case and disease management and quality assurance programs, information systems, and, with respect to our commercial products, reinsurance. Despite our efforts and programs to manage our medical expenses, we may not be able to continue to manage these expenses effectively in the future. If our medical expenses increase, our profits could be reduced or we may not remain profitable.

Our Failure to Estimate IBNR Claims Accurately Will Affect Our Reported Financial Results.

Our medical care costs include estimates of our IBNR claims. We estimate our medical expense liabilities using actuarial methods based on historical data adjusted for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services, and other relevant factors. Actual conditions, however, could differ from those we assume in our estimation process. We continually review and update our estimation methods and the resulting accruals and make adjustments, if necessary, to medical expense when the criteria used to determine IBNR change and when actual claim costs are ultimately determined. As a result of the uncertainties associated with the factors used in these assumptions, the actual amount of medical expense that we incur may be materially more or less than the amount of IBNR originally estimated. If our estimates of IBNR are inadequate in the future, our reported results of operations will be negatively impacted. Further, our inability to estimate IBNR accurately may also affect our ability to take timely corrective actions or otherwise establish appropriate premium pricing, further exacerbating the extent of any adverse effect on our results.

Competition in Our Industry May Limit Our Ability to Maintain or Attract Members, Which Could Adversely Affect Our Results of Operations.

We operate in a highly competitive environment subject to significant changes as a result of business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations that compete with us for members. Our principal competitors for contracts, members, and providers vary by local service area and are comprised of national, regional, and local managed care organizations that serve Medicare recipients,

including, among others, UnitedHealth Group, Humana, Inc., and SelectCare of Texas, a subsidiary of Universal

Table of Contents

American Financial Corp. Our failure to maintain or attract members to our health plans could adversely affect our results of operations. We believe changes resulting from the MMA may bring additional competitors into our Medical Advantage service areas. In addition, we face competition from other managed care companies that often have greater financial and other resources, larger enrollments, broader ranges of products and benefits, broader geographical coverage, more established reputations in the national market and our markets, greater market share, larger contracting scale, and lower costs. Such competition may negatively impact our enrollment, financial forecasts, and profitability.

Our Inability to Maintain Our Medicare Advantage Members or Increase Our Membership Could Adversely Affect Our Results of Operations.

A reduction in the number of members in our Medicare Advantage plans, or the failure to increase our membership, could adversely affect our results of operations. In addition to competition, factors that could contribute to the loss of, or failure to attract and retain, members include:

- negative accreditation results or loss of licenses or contracts to offer Medicare Advantage plans;
- negative publicity and news coverage relating to us or the managed healthcare industry generally;
- litigation or threats of litigation against us;
- disenrollment as a result of members choosing a stand-alone PDP; and
- our inability to market to and re-enroll members who enlist with our competitors because of the new annual enrollment and lock-in provisions under the MMA.

A Disruption in Our Healthcare Provider Networks Could Have an Adverse Effect on Our Operations and Profitability.

Our operations and profitability are dependent, in part, upon our ability to contract with healthcare providers and provider networks on favorable terms. In any particular service area, healthcare providers or provider networks could refuse to contract with us, demand higher payments, or take other actions that could result in higher healthcare costs, disruption of benefits to our members, or difficulty in meeting our regulatory or accreditation requirements. In some service areas, healthcare providers may have significant market positions. If healthcare providers refuse to contract with us, use their market position to negotiate favorable contracts, or place us at a competitive disadvantage, then our ability to market products or to be profitable in those service areas could be adversely affected. Our provider networks could also be disrupted by the financial insolvency of a large provider group. Any disruption in our provider network could result in a loss of membership or higher healthcare costs.

Approximately 31% and 33% of our Medicare Advantage members and 32% and 29% of our total revenue as of and for the nine months ended September 30, 2005 and the year ended December 31, 2004, respectively, were related to our Texas operations. A significant proportion of our providers in our Texas market are affiliated with Renaissance Physician Organization, or RPO, a large group of independent physician associations. As of September 30, 2005, physicians associated with RPO served as the primary care physicians for approximately 87% of our members in our Texas market. Our agreements with RPO generally have a term expiring December 31, 2014, but may be terminated sooner by RPO for cause or in connection with a change in control of the company that results in the termination of senior management and otherwise raises a reasonable doubt as to our successor s ability to perform the agreements. If our HMO subsidiary s agreement with RPO were terminated, we would be required to sign direct contracts with the RPO physicians or additional physicians in order to avoid any disruption in care of our members. It could take significant time to negotiate and execute direct contracts, and we would be forced to reassign members to new primary

Table of Contents

care physicians if all of the current primary care physicians did not sign direct contracts. This would result in loss of membership assuming that not all members would accept the reassignment to a new primary care physician. Accordingly, any significant disruption in, or termination of, our relationship with RPO could materially and adversely impact our results of operations. Moreover, RPO s ability to terminate its agreements with us in connection with certain changes in control of the company could have the effect of delaying or frustrating a potential acquisition or other change in control of the company.

We Have Incurred and May Continue to Incur Significant Expenses in Connection with Implementing Our New Prescription Drug Benefits, Which May Have an Adverse Effect on Our Near-Term Operating Results.

We received approval from CMS to provide prescription drug benefits, including stand-alone PDPs, under Medicare Part D. We have begun to incur expenses to upgrade and improve our infrastructure, technology, and systems to manage our new prescription drug benefits. We incurred significant expenses in 2005 as we prepared to provide these prescription drug benefits as of January 1, 2006 and may in the future incur additional expenses. In particular, our expenses incurred in connection with the implementation of our prescription drug benefits related to the following:

- hiring and training of personnel to establish and manage systems, operations, regulatory relationships, and materials;
- systems development and upgrade costs, including hardware, software, and development resources;
- marketing and sales;
- enrolling new members;
- developing and distributing member materials such as ID cards and member handbooks; and
- handling sales inquiry and customer service calls.

Recent Challenges Faced by CMS and Our Plans Information and Reporting Systems Related to Implementation of Part D May Temporarily Disrupt or Adversely Affect Our Plans Relationships with Our Members.

Partially in anticipation of the implementation of Part D, CMS transitioned to new information and reporting systems, which have recently generated confusing and, we believe in some cases, erroneous membership and payment reports concerning our and others Medicare eligibility and enrollment, most of which we believe reflects inadvertently disenrolled dual-eligible and other beneficiaries who were already members of one of our plans. In addition, recent media reports are prevalent concerning the confusion caused by failures in systems and reporting for Part D, particularly as these failures adversely affect the access of dual-eligibles and low income beneficiaries to their prescription drugs. These developments have caused our plans to experience short-term disruptions in their operations and challenged our information and communications systems. Although we believe the current conditions are temporary, there can be no assurance that the current confusion, systems failures, and mistaken payment reports will not temporarily disrupt or adversely affect our plans relationships with our members, which could result in a reduction of our membership and adversely affect our results of operations.

We May Be Unsuccessful in Implementing Our Growth Strategy If We Are Unable to Complete Acquisitions on Favorable Terms or Integrate the Businesses We Acquire into Our Existing Operations, or If We Are Unable to Otherwise Expand into New Service Areas in a Timely Manner in Accordance with Our Strategic Plans.

Depending on acquisition, expansion, and other opportunities, we expect to continue to increase our membership and to expand to new service areas within our existing markets and in

other markets. Opportunistic acquisitions of contract rights and other health plans are an important element of our growth strategy. We may be unable to identify and complete appropriate acquisitions in a timely manner and in accordance with our or our investors expectations for future growth. The market price of businesses that operate Medicare Advantage plans has generally increased recently, which may increase the amount we are required to pay to complete future acquisitions. Some of our competitors have greater financial resources than we have and may be willing to pay more for these businesses. In addition, we are generally required to obtain regulatory approval from one or more state agencies when making acquisitions, which may require a public hearing, regardless of whether we already operate a plan in the state in which the business to be acquired is located. We may be unable to comply with these regulatory requirements for an acquisition in a timely manner, or at all. Moreover, some sellers may insist on selling assets that we may not want, including commercial lines of business, or transferring their liabilities to us as part of the sale of their companies or assets. Even if we identify suitable acquisition targets, we may be unable to complete acquisitions or obtain the necessary financing for these acquisitions on terms favorable to us, or at all.

To the extent we complete acquisitions, we may be unable to realize the anticipated benefits from acquisitions because of operational factors or difficulties in integrating the acquisitions with our existing businesses. This may include the integration of:

- additional employees who are not familiar with our operations;
- new provider networks, which may operate on terms different from our existing networks;
- additional members, who may decide to transfer to other healthcare providers or health plans;
- disparate information technology, claims processing, and record keeping systems; and
- accounting policies, including those that require a high degree of judgment or complex estimation processes, including estimates of IBNR claims, accounting for goodwill, intangible assets, stock-based compensation, and income tax matters.

For all of the above reasons, we may not be able to successfully implement our acquisition strategy. Furthermore, in the event of an acquisition or investment, you should be aware that we may issue stock that would dilute your stock ownership, incur debt that would restrict our cash flow, assume liabilities, incur large and immediate write-offs, incur unanticipated costs, divert management s attention from our existing business, experience risks associated with entering markets in which we have no or limited prior experience, or lose key employees from the acquired entities.

Additionally, we are likely to incur additional costs if we enter new service areas or states where we do not currently operate, which may limit our ability to expand to, or further expand in, those areas. Our rate of expansion into new geographic areas may also be limited by:

- the time and costs associated with obtaining an HMO license to operate in the new area or expanding our licensed service area, as the case may be;
- our inability to develop a network of physicians, hospitals, and other healthcare providers that meets our requirements and those of the applicable regulators;
- competition, which could increase the costs of recruiting members, reduce the pool of available members, or increase the cost of attracting and maintaining our providers;
- the cost of providing healthcare services in those areas;
- demographics and population density; and

the new annual enrollment period and lock-in provisions of the MMA.

Table of Contents

Negative Publicity Regarding the Managed Healthcare Industry Generally or Us in Particular Could Adversely Affect Our Results of Operations or Business.

Negative publicity regarding the managed healthcare industry generally or us in particular may result in increased regulation and legislative review of industry practices that further increase our costs of doing business and adversely affect our results of operations by:

requiring us to change our products and services;

increasing the regulatory burdens under which we operate;

adversely affecting our ability to market our products or services; or

adversely affecting our ability to attract and retain members.

We Are Dependent Upon Our Executive Officers, and the Loss of Any One or More of These Officers and Their Managed Care Expertise Could Adversely Affect Our Business.

Our operations are highly dependent on the efforts of Herbert A. Fritch, our President and Chief Executive Officer, and certain other senior executives, including Jeffrey L. Rothenberger, our Chief Operating Officer, and J. Murray Blackshear, our Executive Vice President, each of whom has been instrumental in developing our business strategy and forging our business relationships. Although certain of our executives, including Messrs. Fritch, Rothenberger, and Blackshear, have entered into employment agreements with us, these agreements may not provide sufficient incentives for those executives to continue their employment with us. The loss of the leadership, knowledge, and experience of Messrs. Fritch, Rothenberger, and Blackshear and our other executive officers could adversely affect our business. Replacing any of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the managed care industry have the breadth and depth of skills and experience of our executive officers. We do not currently maintain key-man life insurance on any of our executive officers.

Violation of the Laws and Regulations Applicable to Us Could Expose Us to Liability, Reduce Our Revenue and Profitability, or Otherwise Adversely Affect Our Operations and Operating Results.

The federal and state agencies administering the laws and regulations applicable to us have broad discretion to enforce them. We are subject, on an ongoing basis, to various governmental reviews, audits, and investigations to verify our compliance with our contracts, licenses, and applicable laws and regulations. An adverse review, audit, or investigation could result in any of the following:

loss of our right to participate in the Medicare program;

loss of one or more of our licenses to act as an HMO or third party administrator or to otherwise provide a service;

forfeiture or recoupment of amounts we have been paid pursuant to our contracts;

imposition of significant civil or criminal penalties, fines, or other sanctions on us and our key employees;

damage to our reputation in existing and potential markets;

increased restrictions on marketing our products and services; and

inability to obtain approval for future products and services, geographic expansions, or acquisitions.

The U.S. Department of Health and Human Services Office of the Inspector General, Office of Audit Services, or OIG, is conducting a national review of Medicare Advantage plans to determine whether they used payment increases consistent with the requirements of the MMA. Under the MMA, when a Medicare Advantage plan receives a payment

increase, it must reduce beneficiary premiums or cost sharing, enhance benefits, put additional payment amounts in a benefit

Table of Contents

stabilization fund, or use the additional payment amounts to stabilize or enhance access. We cannot assure you that the findings of an audit or investigation of our business would not have an adverse effect on us or require substantial modifications to our operations. In addition, private citizens, acting as whistleblowers, are entitled to bring enforcement actions under a special provision of the federal False Claims Act.

Claims Relating to Medical Malpractice and Other Litigation Could Cause Us to Incur Significant Expenses.

From time to time, we are party to various litigation matters, some of which seek monetary damages. Managed care organizations may be sued directly for alleged negligence, including in connection with the credentialing of network providers or for alleged improper denials or delay of care. In addition, Congress and several states have considered or are considering legislation that would expressly permit managed care organizations to be held liable for negligent treatment decisions or benefits coverage determinations. Of the states in which we currently operate, only Texas has enacted legislation relating to health plan liability for negligent treatment decisions and benefits coverage determinations. In addition, our providers involved in medical care decisions may be exposed to the risk of medical malpractice claims. A small percentage of these providers do not have malpractice insurance. As a result of increased costs or inability to secure malpractice insurance, the percentage of physicians who do not have malpractice insurance may increase. Although our network providers are independent contractors, claimants sometimes allege that a managed care organization should be held responsible for alleged provider malpractice, particularly where the provider does not have malpractice insurance, and some courts have permitted that theory of liability.

Similar to other managed care companies, we may also be subject to other claims of our members in the ordinary course of business, including claims arising out of decisions to deny or restrict reimbursement for services.

We cannot predict with certainty the eventual outcome of any pending litigation or potential future litigation, and we cannot assure you that we will not incur substantial expense in defending these or future lawsuits or indemnifying third parties with respect to the results of such litigation. The loss of even one of these claims, if it results in a significant damage award, could have a material adverse effect on our business. In addition, our exposure to potential liability under punitive damage or other theories may significantly decrease our ability to settle these claims on reasonable terms.

We maintain errors and omissions insurance and other insurance coverage that we believe are adequate based on industry standards. Potential liabilities may not be covered by insurance, our insurers may dispute coverage or may be unable to meet their obligations, or the amount of our insurance coverage and/or related reserves may be inadequate. We cannot assure you that we will be able to obtain insurance coverage in the future, or that insurance will continue to be available on a cost-effective basis, if at all. Moreover, even if claims brought against us are unsuccessful or without merit, we would have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly and may distract our management s attention. As a result, we may incur significant expenses and may be unable to effectively operate our business.

The Inability or Failure to Properly Maintain Effective and Secure Management Information Systems, Successfully Update or Expand Processing Capability, or Develop New Capabilities to Meet Our Business Needs Could Result in Operational Disruptions and Other Adverse Consequences.

Our business depends significantly on effective and secure information systems. The information gathered and processed by our management information systems assists us in, among other things, marketing and sales tracking, underwriting, billing, claims processing, medical management, medical care cost and utilization trending, financial and management accounting, reporting, planning and analysis and e-commerce. These systems also support on-line customer service functions, provider and member administrative functions and support tracking and extensive

analyses of medical expenses and outcome data. These information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs and handle our expansion and growth. Any inability or failure to properly maintain management information systems, successfully update or expand processing capability or develop new capabilities to meet our business needs in a timely manner, could result in operational disruptions, loss of existing customers, difficulty in attracting new customers or in implementing our growth strategies, disputes with customers and providers, regulatory problems, increases in administrative expenses, loss of our ability to produce timely and accurate reports and other adverse consequences. To the extent a failure in maintaining effective information systems occurs, we may need to contract for these services with third-party management companies, which may be on less favorable terms to us and significantly disrupt our operations and information flow.

Furthermore, our business requires the secure transmission of confidential information over public networks. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability and loss. Our security measures may be inadequate to prevent security breaches, and our business operations and profitability would be adversely affected by cancellation of contracts, loss of members and potential criminal and civil sanctions if they are not prevented.

Risks Related to the Offering

There Has Been No Prior Public Market for our Common Stock, and Market Volatility May Affect Our Stock Price and the Value of Your Investment Following this Offering.

Prior to this offering there has not been a public market for our common stock. We cannot predict the extent to which a trading market will develop, how liquid that market might become, or whether it will be maintained. The initial public offering price was determined by negotiation between the representatives of the underwriters and us and may not be indicative of prices that will prevail in the trading market. The market prices for securities of managed care companies in general have been volatile and may continue to be volatile in the future. The following factors, in addition to other risk factors described herein, may have a significant impact on the market price of our common stock:

Medicare budget decreases or changes in Medicare premium levels or reimbursement methodologies;

regulatory or legislative changes;

expectations regarding increases or decreases in medical claims and medical care costs;

adverse publicity regarding HMOs, other managed care organizations and health insurers in general;

government action regarding Medicare eligibility;

the termination of any of our material contracts;

announcements relating to our business or the business of our competitors;

conditions generally affecting the managed care industry or our provider networks;

the success of our operating or growth strategies;

the operating and stock price performance of other comparable companies;

changes in expectations of our future growth, financial performance or changes in financial estimates, if any, of public market analysts;

sales of large blocks of our common stock;

sales of our common stock by our executive officers, directors and significant stockholders;

changes in accounting principles; and

the loss of any of our key management personnel.

Table of Contents

In particular, investors purchasing common stock in this offering may not be able to resell their shares at or above the initial public offering price. The stock markets in general, and the markets for healthcare stocks in particular, have experienced substantial volatility that has often been unrelated to the operating performance of particular companies. These broad market fluctuations may adversely affect the trading price of our common stock. In the past, class action litigation has often been instituted against companies whose securities have experienced periods of volatility in market price. Any such litigation brought against us could result in substantial costs and divert management s attention and resources, which could hurt our business, operating results, and financial condition.

If We Are Unable to Implement Effective Internal Controls Over Financial Reporting, Investors Could Lose Confidence in the Reliability of Our Financial Statements, Which Could Result in a Decrease in the Price of Our Common Stock.

Following the offering, we will be required to implement financial, internal, and management control systems to meet our obligations as a public company, including obligations imposed by the Sarbanes-Oxley Act of 2002. We are working with our independent legal, accounting, and financial advisors to identify those areas in which changes should be made to our financial and management control systems. These areas include corporate governance, corporate control, internal audit, disclosure controls and procedures and financial reporting and accounting systems. Consistent with the Sarbanes-Oxley Act and the rules and regulations of the Securities and Exchange Commission, management s assessment of our internal controls over financial reporting and the audit opinion of the Company s independent registered accounting firm as to the effectiveness of our controls will be first required in connection with the Company s filing of its Annual Report on Form 10-K for the fiscal year ending December 31, 2007. If we are unable to timely identify, implement, and conclude that we have effective internal controls over financial reporting or if our independent auditors are unable to conclude that our internal controls over financial reporting are effective, investors could lose confidence in the reliability of our financial statements, which could result in a decrease in the value of our common stock. Our assessment of our internal controls over financial reporting may also uncover weaknesses or other issues with these controls that could also result in adverse investor reaction. These results may also subject us to adverse regulatory consequences.

The Significant Concentration of Ownership of Our Common Stock Will Limit Your Ability to Influence Corporate Activities and Could Adversely Affect the Trading Price of Our Common Stock.

Following the completion of this offering, GTCR and its affiliates will own approximately 28.8% of our outstanding common stock, or approximately 23.9%, assuming the sale of the shares subject to the over-allotment option granted to the underwriters. As a result, GTCR will have substantial influence over the outcome of matters requiring stockholder approval, including the election of directors, amendments to our amended and restated certificate of incorporation, and significant corporate transactions. The interests of GTCR may not always coincide with our interests or the interests of other stockholders. This concentration of ownership may also have the effect of delaying, preventing or deterring a change in control of our company, which could deprive our stockholders of an opportunity to receive a premium for their common stock as part of a sale of our company and might adversely affect the market price of our common stock. In addition, this concentration of stock ownership may adversely affect the trading price of our common stock because investors may perceive disadvantages in owning stock in a company with a significant stockholder. Additionally, pursuant to our amended and restated stockholders agreement, we have agreed to nominate, and the stockholders party thereto have agreed to vote in favor of, two representatives designated by GTCR to serve as directors as described elsewhere in this prospectus, which increases the influence GTCR will have with respect to significant corporate transactions.

Table of Contents

Under Our Amended and Restated Certificate Of Incorporation, the GTCR and Other Non-Employee Directors Will Not Have Any Duty to Refrain From Engaging Directly or Indirectly in the Same or Similar Business Activities or Lines of Business That We Do, Which May Result in the Company Not Having the Opportunity to Pursue a Corporate Opportunity That May Have Been Appropriate or Beneficial for the Company to Undertake.

Under our amended and restated certificate of incorporation, the directors, officers, stockholders, members, managers, employees, and affiliates of GTCR and the GTCR and our other non-employee directors will not have any duty to refrain from engaging directly or indirectly in the same or similar business activities or lines of business that we do. In the event that any GTCR affiliate or entity or non-employee director, as the case may be, acquires knowledge of a potential transaction or matter which may be a corporate opportunity for itself and us, the GTCR fund or non-employee director, as the case may be, will not, unless such opportunity has been expressly offered to such person solely in his capacity as a director of the company, have any duty to communicate or offer such corporate opportunity to us and may pursue such corporate opportunity for itself or direct such corporate opportunity to another person, which may result in the company not having the opportunity to pursue a corporate opportunity that may have been appropriate or beneficial for us to undertake. See Description of Capital Stock Corporate Opportunities and Transactions with GTCR.

Anti-takeover Provisions in Our Organizational Documents Could Make an Acquisition of Us More Difficult and May Prevent Attempts by Our Stockholders to Replace or Remove Our Current Management.

Provisions in our amended and restated certificate of incorporation and our second amended and restated bylaws may delay or prevent an acquisition of us or a change in our management or similar change in control transaction, including transactions in which stockholders might otherwise receive a premium for their shares over then current prices or that stockholders may deem to be in their best interests. In addition, these provisions may frustrate or prevent any attempts by our stockholders to replace or remove our current management by making it more difficult for stockholders to replace members of our board of directors. Because our board of directors is responsible for appointing the members of our management team, these provisions could in turn affect any attempt by our stockholders to replace current members of our management team. These provisions provide, among other things, that:

special meetings of our stockholders may be called only by the chairman of the board of directors, our chief executive officer or by the board of directors pursuant to a resolution adopted by