HealthSpring, Inc.
Form 10-K
April 03, 2006

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UNITED STATES SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549
FORM 10-K

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the Fiscal Year Ended December 31, 2005

OR

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the Transition Period From_____to_____

Commission File Number 001-32739
HealthSpring, Inc.

(Exact Name of Registrant as Specified in Its Charter)

Delaware	20-1821898
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)
44 Vantage Way, Suite 300 Nashville, Tennessee	37228
(Address of Principal Executive Offices)	(Zip Code)

(615) 291-7000

Registrant s telephone number, including area code
Securities registered pursuant to Section 12(b) of the Exchange Act:

Common Stock, par value $0.01 per share	New York Stock Exchange
(Title of Class)	(Name of Each Exchange on which Registered)

Securities registered pursuant to Section 12(g) of the Exchange Act:
NONE

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

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant s knowledge, in definitive proxy or information statements

incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. þ

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer. See definition of accelerated filer and large accelerated filer in Rule 12b-2 of the Exchange Act. Large Accelerated Filer o Accelerated Filer o Non-Accelerated Filer þ

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

The aggregate market value of the Common Stock held by non-affiliates of the registrant, based on the closing price of these shares on the New York Stock Exchange on March 28, 2006, was approximately $576,800,000. For the purposes of this disclosure only, the registrant has assumed that its directors, executive officers, and beneficial owners of 10% or more of the registrant s common stock are affiliates of the registrant, provided that such persons may disclaim such status.

As of March 28, 2006 there were outstanding 57,269,540 shares of the registrant s Common Stock, par value $0.01 per share.

Documents Incorporated by Reference

Portions of the registrant s definitive Proxy Statement for the 2006 Annual Meeting of Stockholders are incorporated by reference into Part III of this Annual Report on Form 10-K.

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SPECIAL NOTE REGARDING FORWARD-LOOKING STATEMENTS

Statements contained in this Annual Report on Form 10-K that are not historical fact may be forward-looking statements within the meaning of Section 21E of the Securities Exchange Act of 1934 (the Exchange Act). In some cases, you can identify forward-looking statements by terms including anticipates, believes, could, estimates, expe intends, may, plans, potential, predicts, projects, should, will, would, and similar expressions intende forward-looking statements. We intend such statements to be covered by the safe harbor provisions for forward-looking statements contained in Section 21E of the Exchange Act. These statements involve known and unknown risks, uncertainties and other factors, including those described in Item 1A. Risk Factors, that may cause our actual results, performance or achievements to be materially different from any future results, performances or achievements expressed or implied by the forward-looking statements. Forward-looking statements reflect our current views with respect to future events and are based on assumptions and subject to risks and uncertainties. Given these

uncertainties, you should not place undue reliance on these forward-looking statements. We undertake no obligation beyond that required by law to update publicly any forward-looking statements for any reason, even if new information becomes available or other events occur in the future. You should read this report and the documents that we reference in this report and have filed as exhibits to this report completely and with the understanding that our actual future results may be materially different from what we expect.

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PART I

Item 1. Business

Overview

HealthSpring, Inc. (sometimes referred to herein as HealthSpring, company, we, us, and our) is a managed ca organization with a primary focus on Medicare, the federal government-sponsored health insurance program for retired U.S. citizens aged 65 and older, qualifying disabled persons, and persons suffering from end-stage renal disease. Our concentration on Medicare, and the Medicare Advantage program in particular, 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 and physician management experience 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. As of December 31, 2005, we were serving 101,281 Medicare members in 105 counties in the states of 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.

Our management team has extensive experience managing providers and provider networks. Through our relationships with providers, in which we create mutually beneficial incentives to efficiently manage medical expenses, we have achieved medical loss ratios, or MLRs, that we believe are below industry averages. We have also implemented comprehensive disease management and utilization management programs, primarily designed to treat our members and promote the wellness of the chronically ill, which generally are the least healthy of our membership and often account for a significant portion of the costs of Medicare managed care populations.

We were incorporated in October 2004 in connection with the leveraged recapitalization of our predecessor, NewQuest, LLC, by us and certain investment funds affiliated with GTCR Golder Rauner II, L.L.C., which we collectively refer to herein as GTCR or the GTCR Funds, together with management, our existing equityholders, lenders, and other investors. (See Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations The Recapitalization) 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.

On February 8, 2006, we completed our initial public offering, or IPO. We sold 10.6 million shares and selling stockholders sold 11.02 million shares of common stock at a price of $19.50 per share. The aggregate net proceeds from the shares of common stock sold by us were approximately $193.3 million, which we used, together with cash on hand, to pay outstanding indebtedness and offering expenses.

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 report and we do not intend the information on or linked to our website to constitute part of this report. We make available our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and any amendments to those reports on our website, free of charge, to individuals interested in acquiring such reports. The reports can be accessed at our website as soon as reasonably practicable after they are electronically filed with, or furnished to, the Securities and Exchange Commission, or SEC. The public may read and copy these materials at the SEC s public reference room located at 100 F. Street, N.E., Washington, D.C. 20549 or on their website at http://www.sec.gov. Questions regarding the operation of the public reference room may be directed to the SEC at 1-800-732-0330. References to HealthSpring, company, we, our, and us refer to HealthSpring, Inc. together with our subsidiaries and our predecessor entities, unless the context suggests otherwise.

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The Medicare Program and Medicare Managed Care

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 & Medicaid Services, or CMS. The Medicare program, created in 1965, offers both hospital insurance, known as Medicare Part A, and medical insurance, known as Medicare Part B. In general, Medicare Part A covers hospital care and some nursing home, hospice, and home care. Although there is no monthly premium for Medicare Part A, beneficiaries are responsible for significant deductibles and co-payments. All United States citizens eligible for Medicare are automatically enrolled in Medicare Part A when they turn 65. Enrollment in Medicare Part B is voluntary. In general, Medicare Part B covers outpatient hospital care, physician services, laboratory services, durable medical equipment, and some other preventive tests and services. Beneficiaries that enroll in Medicare Part B pay a monthly premium that is usually withheld from their Social Security checks. Medicare Part B generally pays 80% of the cost of services and beneficiaries pay the remaining 20% after the beneficiary has satisfied a deductible. To fill the gaps in traditional fee-for-service Medicare coverage, individuals have the option to purchase Medicare supplement products, commonly known as Medigap, to cover deductibles, copayments, and coinsurance.

Initially, Medicare was offered only on a fee-for-service basis. Under the Medicare fee-for-service payment system, an individual can choose any licensed physician and use the services of any hospital, healthcare provider, or facility certified by Medicare. CMS reimburses providers if Medicare covers the service and CMS considers it medically necessary. There is currently no fee-for-service coverage for certain preventive services, including annual physicals and wellness visits, eyeglasses, hearing aids, dentures, and most dental services.

As an alternative to the traditional fee-for-service Medicare program, in geographic areas where a managed care plan has contracted with CMS pursuant to the Medicare Advantage program, Medicare beneficiaries may choose to receive benefits from a managed care plan. The current Medicare managed care program was established in 1997 when Congress created a Medicare Part C, formerly known as Medicare+Choice and now known as Medicare Advantage. Pursuant to Medicare Part C, Medicare Advantage plans contract with CMS to provide benefits at least comparable to those offered under the traditional fee-for-service Medicare program in exchange for a fixed monthly premium payment per member per month, or PMPM, from CMS. The monthly premium varies based on the county in which the member resides, as adjusted to reflect the member s demographics and the plans risk scores as more fully described below. Individuals who elect to participate in the Medicare Advantage program often receive greater benefits than traditional fee-for-service Medicare beneficiaries such as additional preventive services and dental and vision benefits. Medicare Advantage plans typically have lower deductibles and co-payments than traditional fee-for-service Medicare, and plan members do not need to purchase supplemental Medigap policies. In exchange for these enhanced benefits, members are generally required to use only the services and provider network provided by the Medicare Advantage plan. Most Medicare Advantage plans have no additional premiums. In some geographic areas, however, and for plans with open access to providers, members may be required to pay a monthly premium.

Prior to 1997, CMS reimbursed health plans participating in the Medicare program primarily on the basis of the demographic data of the plans members. One of CMS s primary directives in establishing the Medicare Advantage program was to make it more attractive to managed care plans to enroll members with higher intensity illnesses. To accomplish this, CMS implemented a risk adjustment payment system for Medicare health plans in 1997 pursuant to the Balanced Budget Act of 1997. This payment system was further modified pursuant to the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. CMS is phasing-in this risk adjustment payment methodology with a model that bases a portion of the total CMS reimbursement payments on various clinical and demographic factors including hospital inpatient diagnoses, additional diagnosis data from ambulatory treatment settings, hospital outpatient department 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. Under this system, the risk adjusted portion of the total CMS payment to the Medicare Advantage plans will equal the local rate set forth in the traditional demographic rate book, adjusted to reflect the plan s average gender, age, and disability demographics. During 2003, risk adjusted payments accounted for only 10% of Medicare health plan payments, with the remaining 90% being reimbursed in accordance

with the traditional demographic rate book. 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.

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The 2003 Medicare Modernization Act

Overview. In December 2003 Congress passed the Medicare Prescription Drug, Improvement and Modernization Act, which is known as the Medicare Modernization Act, or MMA. The MMA increased the amounts payable to Medicare Advantage plans such as ours and expanded Medicare beneficiary healthcare options, including adding a Medicare Part D prescription drug benefit beginning in 2006, as further described below.

One of the goals of the MMA was to reduce the costs of the Medicare program by increasing participation in the Medicare Advantage program. Beginning in 2004, the MMA adjusted Medicare Advantage statutory payment rates to 100% of Medicare s expected cost per beneficiary under the traditional fee-for-service program. Generally, this adjustment resulted in an increase in payments per member to Medicare Advantage plans. Medicare Advantage plans are required to use these increased payments to improve the healthcare benefits that are offered, to reduce premiums, or to strengthen provider networks. We believe the reforms proposed by the MMA, including in particular the increased reimbursement rates to Medicare Advantage plans, have allowed and will continue to allow Medicare Advantage plans to offer more comprehensive and attractive benefits, including better preventive care and dental and vision benefits, while also reducing out-of-pocket expenses for beneficiaries. As a result of these reforms, we expect enrollment in Medicare s managed care programs to increase in the coming years.

Prescription Drug Benefit. As part of the MMA, effective January 1, 2006, every Medicare recipient is able to select a prescription drug plan through Medicare Part D. Medicare Part D replaced the transitional prescription drug discount program and replaced Medicaid prescription drug coverage for beneficiaries eligible for participation under both the Medicare and Medicaid programs, or dual-eligibles. The Medicare Part D prescription drug benefit is largely subsidized by the federal government and is additionally supported by risk-sharing with the federal government through risk corridors designed to limit the profits or losses of the drug plans and reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for member demographics and risk factor payments. The beneficiary is responsible for the difference between the government subsidy and his or her plan s bid, together with the amount of his or her plan s supplemental premium (before rebate allocations), subject to the co-pays, deductibles, and late enrollment penalties, if applicable, described below. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries.

The Medicare Part D benefits are available to Medicare Advantage plan enrollees as well as Medicare fee-for-service enrollees. Medicare Advantage plan enrollees who elect to participate may pay a monthly premium for this Medicare Part D prescription drug benefit, or MA-PD, while fee-for-service beneficiaries will be able to purchase a stand-alone prescription drug plan, or PDP, from a list of CMS-approved PDPs available in their area. Our Medicare Advantage members were automatically enrolled in our MA-PD plans as of January 1, 2006 unless they chose another provider s prescription drug coverage or one of our other plan options without drug coverage. Any Medicare Advantage member enrolling in a stand-alone PDP, however, is automatically disenrolled from the Medicare Advantage plan altogether, thereby resuming traditional fee-for-service Medicare. In addition, certain dual-eligible beneficiaries are automatically enrolled with approved PDPs in their region. Under the standard Part D drug coverage for 2006, beneficiaries enrolled in a stand-alone PDP pay a $250 deductible, co-insurance payments equal to 25% of the drug costs between $250 and the initial annual coverage limit of $2,250, and all drug costs between $2,250 and $5,100, which is commonly referred to as the Part D doughnut hole. After the beneficiary has incurred $3,600 in out-of-pocket drug expenses, the MMA provides stop loss coverage that will cover approximately 95% of the beneficiaries remaining out-of-pocket drug costs for that year. MA-PDs are not required to mirror these limits, but are required to provide, at a minimum, coverage that is actuarially equivalent to the standard drug coverage delineated in the MMA. The deductible, co-pay, and coverage amounts will be adjusted by CMS on an annual basis. As additional incentive to enroll in a Part D prescription drug plan, CMS will impose a cumulative penalty added to a beneficiary s monthly Part D plan premium in an amount equal to 1% of the applicable premium for each month between the date of a beneficiary s enrollment deadline and the beneficiary s actual enrollment. This penalty amount will be passed through the plan to the government. Each Medicare Advantage plan is required to offer a Part D drug prescription plan as part of its benefits. We currently offer MA-PD benefits and stand-alone PDPs in each of our markets.

Dual-Eligible Beneficiaries. A dual-eligible beneficiary is a person who is eligible for both Medicare, because of age or other qualifying status, and Medicaid, because of economic status. Health plans that serve dual-

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eligible beneficiaries receive a higher premium from CMS for dual-eligible members. CMS pays an additional premium for a dually-eligible beneficiary based upon the estimated incremental cost CMS incurs, on average, to care for dual-eligible beneficiaries. By managing utilization and implementing disease management programs, many Medicare Advantage plans can profitably care for dually-eligible members. The MMA provides subsidies and reduced or eliminated deductibles for certain low-income beneficiaries, including dual-eligible individuals. Pursuant to the MMA, as of January 1, 2006 dual-eligible individuals receive their drug coverage from the Medicare program rather than the Medicaid program. Companies offering stand-alone PDPs with bids at or below the regional weighted average bid resulting from the annual bidding process received a pro-rata allocation and auto-enrollment of the dual-eligible beneficiaries within their applicable region.

2006 Bidding Process. Although Medicare Advantage plans will continue to be paid on a capitated, or PMPM basis, as of January 1, 2006 CMS implemented a new rate calculation system for Medicare Advantage plans. The new system is based on a competitive bidding process that allows the federal government to share in any cost savings achieved by Medicare Advantage plans. In general, the statutory payment rate for each county, which is primarily based on CMS s estimated per beneficiary fee-for-service expenses, was relabeled as the benchmark amount, and local Medicare Advantage plans will annually submit bids that reflect the costs they expect to incur in providing the base Medicare Part A and Part B benefits in their applicable service areas. If the bid is less than the benchmark for that year, Medicare will pay the plan its bid amount, risk adjusted based on its risk scores, plus a rebate equal to 75% of the amount by which the benchmark exceeds the bid, resulting in an annual adjustment in reimbursement rates. Plans will be required to use the rebate to provide beneficiaries with extra benefits, reduced cost sharing, or reduced premiums, including premiums for MA-PD and other supplemental benefits. CMS will have the right to audit the use of these proceeds. The remaining 25% of the excess amount will be retained in the statutory Medicare trust fund. If a Medicare Advantage plan s bid is greater than the benchmark, the plan will be required to charge a premium to enrollees equal to the difference between the bid amount and the benchmark, which is expected to make such plans less competitive. For 2006, the county benchmarks equals the 2005 rates increased by 4.8%, which is the national growth rate in fee-for-service expenditures.

Annual Enrollment and Lock-in. Prior to the MMA, Medicare beneficiaries were permitted to enroll in a Medicare managed care plan or change plans at any point during the year. As of January 1, 2006, Medicare beneficiaries have defined enrollment periods, similar to commercial plans, in which they can select a Medicare Advantage plan, stand-alone PDP, or traditional fee-for-service Medicare. The initial enrollment period for 2006 began November 15, 2005 and continues through May 15, 2006 for a MA-PD or stand-alone PDP. In addition, beneficiaries will have an open election period from January 1, 2006 through June 30, 2006 in which they can make or change an equivalent election. Thereafter, the annual enrollment period for a PDP will be from November 15 through December 31 of each year, and enrollment in Medicare Advantage plans will occur from November 15 through March 31 of the subsequent year. Enrollment on or prior to December 31 will be effective as of January 1 of the following year and enrollment on or after January 1 and within the enrollment period will be effective as of the first day of the month following the date on which the enrollment occurred. After these defined enrollment periods end, generally only seniors turning 65 during the year, Medicare beneficiaries who permanently relocate to another service area, dual-eligible beneficiaries and others who qualify for special needs plans, and employer group retirees will be permitted to enroll in or change health plans during that plan year. Eligible beneficiaries who fail to timely enroll in a Part D plan will be subject to the penalties described above under Prescription Drug Benefit if they later decide to enroll in a Part D plan.

Products and Services

We offer Medicare Advantage health plans, including MA-PD plans and stand-alone PDPs, in each of our markets. Our Medicare Advantage plans cover Medicare eligible members with benefits that are at least comparable to those offered under traditional Medicare fee-for-service plans. Through our plans, we have the flexibility to offer benefits not covered under traditional fee-for-service Medicare. Our plans are designed to be attractive to seniors and offer a broad range of benefits that vary across our markets and service areas but may include, for example, mental health benefits, dental, vision and hearing benefits, transportation services, preventive health services such as health and fitness programs, routine physicals, various health screenings, immunizations, chiropractic services, and

mammograms. Most of our MA-PD members pay no monthly premium in addition to the premium we receive from Medicare but are subject in some cases to co-payments and deductibles, depending upon the market and benefit. Our members are required to use a primary care physician within our network of providers, except in limited cases,

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including emergencies, and generally must receive referrals from their primary care physician in order to see a specialist or other ancillary provider**.** In addition to our typical Medicare Advantage benefits, we offer a special needs zero premium, zero co-payment plan to dual-eligible individuals in each of our markets.

The amount of premiums we receive for each Medicare member is established by contract, although it varies according to various demographic factors, including the member s geographic location, age, and gender, and is further adjusted based on our plans average risk scores. During the month of December 2005, our Medicare premiums across our service areas ranged from an average of $650.13 to $781.31 PMPM. In addition to the premiums payable to us, our contracts with CMS regulate, among other matters, benefits provided, quality assurance procedures, and marketing and advertising for our Medicare products.

In addition to our Medicare products, we offer commercial managed care products and services in certain of our markets. Our commercial plans cover individuals and employer groups with medical coverage and benefits that differ from plan to plan for a set monthly premium. Our commercial products include:

commercial HMO plans in Alabama and Tennessee;

PPO network rental, which allows third party administrators to use our provider network for an access fee, in Tennessee;

exclusive provider organization, or EPO, products for self-insured employers in Tennessee that provide access to our provider networks at negotiated rates; and

administrative services only, or ASO, products for self-insured employers in Tennessee.

We also offer management services to independent physician associations in our Alabama, Tennessee, and Texas markets, including claims processing, provider relations, credentialing, reporting and other general business office services.

Our Health Plans

We operate in each of our five markets through HMO subsidiaries. Each of the HMO subsidiaries is regulated by the department of insurance, and in some cases the department of health, in its respective state. In addition, we own and operate management company subsidiaries that provide administrative and management services to the HMO subsidiaries in exchange for a percentage of the HMO subsidiaries income pursuant to management agreements and administrative services agreements. Those services include:

negotiation, monitoring, and quality assurance of contracts with third party healthcare providers;

medical management, credentialing, marketing, and product promotion;

support services and administration;

personnel recruiting and retention;

financial services; and

claims processing and other general business office services.

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The following table summarizes our Medicare Advantage and commercial plan membership as of the dates indicated:

	December 31,		
	2005	**2004**	**2003**
Medicare Advantage Membership			
Tennessee	42,509	29,862	25,772
Texas	29,706	21,221	15,637
Alabama	24,531	12,709	6,490
Illinois(1)	4,166		
Mississippi(2)	369		
Total	101,281	63,792	47,899
Commercial Membership(3)			
Tennessee	29,859	32,139	32,668
Alabama	11,910	16,241	21,612
Total	41,769	48,380	54,280

(1) We commenced operations in Illinois in December 2004.

(2) We commenced enrollment efforts in Mississippi in July 2005.

(3) Does not include members of commercial PPOs owned and operated by unrelated third parties that pay us a fee for access to our contracted provider network.

Tennessee

We began operations in Tennessee in September 2000 when we purchased a 50% interest in an unprofitable HMO in the Nashville, Tennessee area that offered commercial and Medicare products. When we purchased the plan, it had approximately 8,000 Medicare Advantage members in five counties and 22,000 commercial members in 27 counties. We purchased an additional 35% interest in the HMO in 2003 and purchased the remaining 15% in March 2005. As of December 31, 2005, our Tennessee HMO, known as HealthSpring of Tennessee, had approximately 72,400 members

in 27 counties, including approximately 42,500 Medicare Advantage members, and 29,900 commercial members. In addition, through Signature Health Alliance, our wholly-owned PPO network subsidiary, we provided repricing and access to our provider networks for approximately 83,100 members as of December 31, 2005 throughout the 20-county area of Middle Tennessee.

As of December 31, 2005, there were approximately 944,300 Medicare beneficiaries in the State of Tennessee, including approximately 437,300 Medicare beneficiaries in the counties in which we currently operate. Our Tennessee market is primarily divided into three major service areas including Middle Tennessee, the three-county greater Memphis area, and the four-county greater Chattanooga area. As of December 31, 2005, approximately 10.9% of the Medicare beneficiaries in these service areas participated in a Medicare Advantage plan, compared to 10.1% of Medicare beneficiaries on a statewide basis.

We believe there are currently four competing Medicare Advantage plans in our service areas in Tennessee and that we held the leading market position as of December 31, 2005, based on membership, in these areas. Our principal competitors in these service areas are UnitedHealth Group, Humana, Inc., Sterling Life Insurance Company, and Cariten Healthcare.

Texas

We began operations in Texas in November 2000 as an independent physician association management company. We began operating an HMO in Texas in November 2002 when we acquired approximately 7,800 Medicare lives from a managed care plan in state receivership. As of December 31, 2005, our Texas HMO, known as Texas HealthSpring, had approximately 29,700 Medicare Advantage members in 20 counties in Southeast Texas, Northeast Texas, and the Rio Grande Valley.

As of December 31, 2005, there were approximately 2.6 million Medicare beneficiaries in the State of Texas, including approximately 701,000 Medicare beneficiaries in the counties in which we currently operate. Our Texas

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market is primarily divided into three major service areas including, the 14-county greater Houston area, a four-county Northeast Texas area, and a two-county Rio Grande Valley area. As of December 31, 2005, approximately 8.9% of the Medicare beneficiaries in these major service areas participated in a Medicare Advantage plan, compared to 8.7% of the Medicare beneficiaries on a statewide basis.

We believe there are currently four competing Medicare Advantage plans in our service areas in Texas and that we held the leading market position as of December 31, 2005, based on membership. Our principal competitors in these service areas are Humana, Inc., XLHealth, Universal American Financial Corp., doing business as SelectCare of Texas, and UnitedHealth Group, doing business as EverCare.

Alabama

We began operations in Alabama in November 2002 when we purchased an HMO with approximately 23,000 commercial members and approximately 2,800 Medicare members in two counties. As of December 31, 2005, HealthSpring of Alabama served over 36,400 members, including approximately 24,500 Medicare Advantage members and 11,900 commercial members, in 42 counties.

We recently decided to discontinue offering commercial benefits to individuals and small group employers in Alabama effective June 1, 2006. Prior to June 1, 2006, small employer groups currently enrolled in our commercial plans may elect to continue participating in our plans through June 30, 2007. As of December 31, 2005, there were 1,417 commercial members participating in our individual and small employer group plans in Alabama. Pursuant to Alabama law, as a result of our decision to exit the individual and small group commercial markets, we may not re-enter the individual and small group employer commercial markets in Alabama until November 30, 2010.

As of December 31, 2005, there were approximately 774,000 Medicare beneficiaries in the State of Alabama, including approximately 551,000 Medicare beneficiaries in the 42 counties in which we currently operate. As we generally operate statewide, we do not have distinct primary service areas in Alabama. As of December 31, 2005, approximately 13.5% of the Medicare beneficiaries in the counties in which we operate participated in a Medicare Advantage plan, compared to 9.7% of the Medicare beneficiaries statewide. We believe there are currently two competing Medicare Advantage plans in our service areas in the State of Alabama, and that our market position as of December 31, 2005, based on membership, was second. Our principal competitors in these service areas are UnitedHealth Group and Viva Health, a member of the University of Alabama at Birmingham Health System.

Illinois

We began operations in Illinois in December 2004 and, as of December 31, 2005, our Medicare Advantage plan in Illinois, known as HealthSpring of Illinois, served approximately 4,100 beneficiaries in eight counties in the Chicago area. HealthSpring of Illinois is one of four managed care companies currently offering competing Medicare Advantage plans that operate in the greater Chicago metropolitan area, and we believe our primary competitor is Humana, Inc.

As of December 31, 2005, there were approximately 1.7 million Medicare beneficiaries in the State of Illinois, including over one million Medicare beneficiaries in the eight counties in which we currently operate. As of December 31, 2005, approximately 43,000, or 4.2%, of the Medicare beneficiaries in the counties in which we operate participated in a Medicare Advantage plan, compared to 5.0% of the Medicare beneficiaries statewide. Prior to the impact of the budget restrictions and other changes to the Medicare program following the BBA, there were approximately 150,000 Medicare beneficiaries in the Chicago metropolitan area enrolled in Medicare managed care plans.

Mississippi

We commenced our enrollment efforts in July 2005 for our Medicare Advantage plan, known as HealthSpring of Mississippi, in two counties in northern Mississippi located near Memphis, Tennessee. We entered these service areas consistent with our growth strategy to leverage existing operations to expand to new service areas located near or contiguous to our existing service areas. We are licensed and intend to expand our operations in our Mississippi

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market to include six counties in southern Mississippi located near Mobile, Alabama. Those expansion efforts were temporarily delayed as a result of Hurricane Katrina, and have recently been resumed.

As of December 31, 2005, there were approximately 468,000 Medicare beneficiaries in the State of Mississippi, including approximately 88,000 Medicare beneficiaries in our service areas in Mississippi. Currently, we believe there are two other managed care companies offering competing Medicare Advantage plans in the State of Mississippi: Tenet Healthcare Corporation and Humana, Inc.

Medical Health Services Management and Provider Networks

One of our primary goals is to arrange for high quality healthcare for our members. To achieve our goal of ensuring high quality, cost-effective healthcare, we have established various quality management programs, including disease management and utilization management programs.

Our disease management programs are focused on prevention and care and are designed to support the coordination of healthcare intervention, physician/patient relationships and plans of care, preventive care, and patient empowerment with the goal of improving the quality of patient care and controlling related costs. Our disease management programs are focused primarily on high-risk care management and the treatment of our chronically ill members. These programs are designed to efficiently treat patients with specific high risk or chronic conditions such as coronary artery disease, congestive heart failure, prenatal and premature infant care, end stage renal disease, diabetes, asthma related conditions, and certain other conditions. In addition to internal disease management efforts, we have partnered with outsourced disease management companies to educate members on chronic medical conditions, help them comply with medication regimens, and counsel members on healthy lifestyles.

We also have implemented utilization, or case, management programs to provide more efficient and effective use of healthcare services by our members. Our case management programs are designed to improve outcomes for members with chronic conditions through standardization, proactive management, coordinating fragmented healthcare systems to reduce duplication, provide gate-keeping services, and improve collaboration with physicians. We have partners that monitor hospitalization, coordinate care, and ensure timely discharge from the hospital. In addition, we use internal case management programs and contracts with other third parties to manage severely and chronically ill patients. We utilize on-site critical care intensivists, hospitalists and concurrent review nurses, who manage the appropriate times for outpatient care, hospitalization, rehabilitation or home care. We also offer prenatal case management programs as part of our commercial plans.

We have information technology systems that support our quality improvement and management activities by allowing us to identify opportunities to improve care and track the outcomes of the services provided to achieve those improvements. We utilize this information as part of our monthly analytical reviews described above and to enhance our preventive care and disease and case management programs where appropriate.

Additionally, we internally monitor and evaluate, and seek to enhance, the performance of our providers. Our related programs include:

- review of utilization of preventive measures and disease/case management resources and related outcomes;
- member satisfaction surveys;
- review of grievances and appeals by members and providers;
- orientation visits to, and site audits of, select providers;
- ongoing provider and member education programs; and
- medical record audits.

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As more fully described below under Provider Arrangements and Payment Methods, our reimbursement methods are also designed to encourage providers to utilize preventive care and our other disease and case management services in an effort to improve clinical outcomes.

We believe strong provider relationships are essential to increasing our membership, improving the quality of care to our members and making our health plans profitable. We have established comprehensive networks of providers in each of the areas we serve. We seek providers who have experience in managing the Medicare population, including through a risk-sharing or other relationship with a Medicare Advantage plan. Our goal is to create mutually beneficial and collaborative arrangements with our providers. We believe provider incentive arrangements should not only help us attract providers, but also help align their interests with our objective of providing high-quality, cost-effective healthcare and ultimately encourage providers to deliver a level of care that promotes member wellness, reduces avoidable catastrophic outcomes, and improves clinical results.

The following table shows the approximate number of physicians, specialists, and other providers participating in our Medicare Advantage networks as of December 31, 2005:

Market	Primary Care Physicians	Specialists	Hospitals	Ancillary Providers
Tennessee	1,198	3,057	53	353
Texas	607	942	44	277
Alabama	726	2,168	44	315
Illinois	458	1,441	24	306
Mississippi	21	17	1	2
Total	3,010	7,625	166	1,253

In our efforts to improve the quality and cost-effectiveness of heathcare for our members, we continue to refine and develop new methods of medical management and physician engagement. Two such initiatives are currently underway. We have had encouraging preliminary results from the initial pilot of our pay-for-performance initiative, which provides quality and outcomes-based financial incentives to physicians, with a single medical group in Tennessee. The program, as piloted, includes an in-office resource, usually a nurse, in the physician practice that is dedicated to serving our members. We also provide a dedicated call center resource for disease management support. We are currently in the process of expanding the program to physician offices in Tennessee, Alabama, and Texas to determine whether the early results can be replicated across markets.

We are also planning to open later in 2006 our first clinic dedicated to our Medicare plan members, partnering with the same medical group in Tennessee that experienced the encouraging pay-for-performance results discussed above. The clinic will be designed with the Medicare member in mind, with amenities designed to minimize any barrier to patient access such as single floors (no elevators or stairs); adjacent parking or valet service and, in some cases pick-up and return services; open reception areas; on-site nutritionists, dieticians, and nurse educators; wide corridors and doors; handicapped-accessible facilities; and electronic medical records. We believe clinics have the potential to improve member satisfaction, service levels, and clinical outcomes and provide for a more satisfying and cost-efficient manner for the physician to deliver care. We also believe clinics will give us an advantage over our competitors, creating a more attractive network for our members.

Generally, we contract for pharmacy services through an unrelated pharmacy benefits manager, or PBM, who is reimbursed at a discount to the average wholesale price for the provision of covered outpatient drugs. In addition, our HMOs are entitled to share in the PBM s rebates based on pharmacy utilization relating to certain qualifying medications. We also contract with a third party behavioral health vendor who provides mental health and substance abuse services for our members.

We strive to be the preferred Medicare Advantage partner for providers in each market we serve. In addition to risk-sharing and other incentive-based financial arrangements, we seek to promote a provider-friendly relationship by paying claims promptly, providing periodic performance and efficiency evaluations, providing convenient, web-based

access to eligibility data and other information, and encouraging provider input on plan benefits. We also emphasize quality assurance and compliance by periodically reviewing our networks and providers. By fostering a collaborative, interactive relationship with our providers, we are better able to gather data relevant to improving the

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level of preventive healthcare available under our plans, monitor the utilization of medical treatment and the accuracy of patient encounter data, risk coding and the risk scores of our plans, and otherwise ensure our contracted providers are providing high-quality and timely medical care.

Provider Arrangements and Payment Methods

We attempt to structure our provider arrangements and payment methods in a manner that encourages the medical provider to deliver high quality medical care to our members. We also attempt to structure our provider contracts in a way that mitigates some or all of our medical risk either through capitation or other risk-sharing arrangements. In general, there are two types of medical risk professional and institutional. Professional risk primarily relates to physician and other outpatient services. Institutional risk primarily relates to hospitalization and other inpatient or institutionally-based services.

We generally pay our providers under one of three payment methods:

fee-for-service, based on a negotiated fixed-fee schedule where we are fully responsible for managing institutional and professional risk;

capitation, based on a PMPM payment, where physicians generally assume the professional risk, or on a case-rate or per diem basis where a hospital or health system generally assumes the institutional or professional risk, or both; and

risk-sharing arrangements, typically with a physician group, where we advance, on a PMPM basis, amounts designed to cover the anticipated professional risk and then adjust payments, on a monthly basis, between us and the physician group based on actual experience measured against pre-determined sharing ratios.

Under any of these payment methods, we may also supplement provider payments with incentive arrangements based, in general, on the quality of healthcare delivery. For example, as an incentive to encourage our providers to deliver high quality care for their patients and assist us with our quality assurance and medical management programs, we often seek to implement incentive arrangements whereby we compensate our providers for quality performance, including increased fee-for-service rates for specified preventive health services and additional payments for providing specified encounter data on a timely basis. We also seek to implement financial incentives relating to other operational matters where appropriate.

In some cases, particularly with respect to contracts between hospitals or health care systems and our commercial health plans, we may be at risk for medical expenses above and beyond a negotiated amount (a so-called stop loss provision), which amount is typically calculated by reference to a percentage of billed charges, in some cases back to the first dollar of medical expense. When our members receive services for which we are responsible from a provider with whom we have not contracted, such as in the case of emergency room services from non-contracted hospitals, we generally attempt to negotiate a rate with that provider. In some cases, we may be obligated to pay the full rate billed by the provider. In the case of a Medicare patient who is admitted to a non-contracting hospital, we are only obligated to pay the amount that the hospital would have received from CMS under traditional fee-for-service Medicare.

We believe our incentive and risk-sharing arrangements with physicians help to align their interests with us and our members and improve both clinical and financial outcomes. We will continue to seek to implement these arrangements where possible in our existing and new service areas.

Sales and Marketing Programs

As of December 31, 2005, our sales force consisted of approximately 700 independent agents and 80 internal licensed sales employees (including in-house telemarketing personnel). Our independent agents are compensated on a commission basis. Medicare Advantage enrollment is generally a decision made individually by the member. Accordingly, our sales agents and representatives focus their efforts on in-person contacts with potential enrollees. In addition to traditional marketing methods including direct mail, telemarketing, radio, internet and other mass media, and cooperative advertising with participating hospitals and medical groups to generate leads, we also conduct community outreach programs in churches and community centers and in coordination with government

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agencies. We regularly participate in local community health fairs and events, and seek to become involved with local senior citizen organizations to promote our products and the benefits of preventive care. Our sales and marketing programs are tailored to each of our local service areas and are designed with the goal of educating, attracting, and retaining members and providers. In addition, we seek to create ethnically and culturally competent marketing programs where appropriate that reflect the diversity of the areas that we serve.

Our marketing and sales activities are heavily regulated by CMS and other governmental agencies. For example, CMS has oversight over all, and in some cases has imposed advance approval requirements with respect to, marketing materials used by our Medicare Advantage plans, and our sales activities are limited to activities such as conveying information regarding the benefits of preventive care, describing the operations of managed care plans, and providing information about eligibility requirements. The activities of our third-party brokers and agents are also heavily regulated.

Prior to 2006, Medicare beneficiaries could enroll in or change health plans at any time during the year. As of January 1, 2006, Medicare beneficiaries have a limited annual enrollment period during which they can choose between a Medicare Advantage plan and traditional fee-for-service Medicare. After this annual enrollment period ends, generally only seniors turning 65 during the year, dual-eligible beneficiaries and others who qualify for special needs plans, Medicare beneficiaries permanently relocating to another service area, and employer group retirees will be permitted to enroll in or change health plans. The annual enrollment period for 2006 is November 15, 2005 through May 15, 2006 for stand-alone PDPs and through June 30, 2006 for Medicare Advantage plans. Thereafter, the annual enrollment period will be from November 15 through December 31 each year for stand-alone PDPs and through March 31 of the following year for Medicare Advantage plans. Although our experience to date with the prospect of limited enrollment has not resulted in significant changes to our sales and marketing efforts, we have not fully determined whether the impact of limited enrollment will adversely affect such efforts or our sales and marketing personnel or our business as a whole.

Quality Assurance

As part of our quality assurance program, we have implemented processes designed to ensure compliance with regulatory and accreditation standards. Our quality assurance program also consists of internal programs that credential providers and programs designed to help ensure we meet the audit standards of federal and state agencies, including CMS and the state departments of insurance, as well as applicable external accreditation standards. For example, we monitor and educate, in accordance with audit tools developed by CMS, our claims, credentialing, customer service, enrollment, health services, providers relations, contracting, and marketing departments with respect to compliance with applicable laws, regulations, and other requirements.

Our providers must satisfy specific criteria, such as licensing, credentialing, patient access, office standards, after-hours coverage, and other factors. Our participating hospitals must also meet specific criteria, including accreditation criteria established by CMS.

Competition

We operate in an increasingly competitive environment. Our principal competitors for contracts, members, and providers vary by local service area and are principally national, regional and local commercial managed care organizations that serve Medicare recipients, including, among others, UnitedHealth Group, Humana, Inc., and Universal American Financial Corp. In addition, the MMA (including Medicare Part D) may cause a number of commercial managed care organizations, some of which are already in our service areas, to decide to enter the Medicare Advantage market. Furthermore, the implementation of Medicare Part D prescription drug benefits in 2006 has attracted national and regional pharmaceutical distributors and retailers, pharmacy benefit managers, and managed care organizations to our markets and provide services and benefits to the Medicare eligible population. Pursuant to the MMA, a regional Medicare PPO program was implemented as of January 1, 2006. Medicare PPOs allow their members more flexibility to select physicians than HMO Medicare Advantage plans. The new regional Medicare PPO plans will compete with local Medicare Advantage HMO plans, including the plans we offer.

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We believe the principal factors influencing a Medicare recipient s choice among health plan options are:

additional premiums, if any, payable by the beneficiary;

benefits offered;

location and choice of healthcare providers;

quality of customer service and administrative efficiency;

reputation for quality care;

financial stability of the plan; and

accreditation results.

A number of these competitive elements are partially dependent upon and can be positively affected by financial resources available to a health plan. We face competition from other managed care companies that 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 in our markets, greater market share, larger contracting scale, and lower costs. Superior benefit design, provider network, and community perception may also provide a distinct competitive advantage. If a competing plan is able to gain a competitive advantage over us in our markets, it may negatively impact our enrollment and profitability.

Our Competitive Advantages

We believe the following are our key competitive advantages:

Focus on Medicare Advantage Market. We are focused primarily on Medicare. We believe our focus on designing and operating Medicare health plans tailored to each of our local service areas enables us to offer superior Medicare plans and to operate those plans with what we believe to be lower MLRs. Our focus allows us to:

build relationships with provider networks that deliver the care desired by Medicare beneficiaries in their local service areas at contractual rates that take into account Medicare reimbursement schedules;

direct our sales and marketing efforts primarily to Medicare beneficiaries and their families, customized to the demographics of the communities in which we operate; and

staff each of our service areas with locally-based senior managers who understand the particular dynamics influencing behavior of local Medicare beneficiaries and providers as well as political and legislative impacts on our programs.

Leading Presence in Attractive, Underpenetrated Markets. We have a significant market position in our established service areas and in many of our service areas we are the market leader in terms of the number of members. Although Medicare Advantage penetration is highly variable across the country as a result of numerous factors, including infrastructure and provider accessibility, our service areas in particular are underpenetrated, providing opportunities for increased membership. In our current service areas the percentage of Medicare eligible beneficiaries that were enrolled in our or a competitor s Medicare Advantage plan as of December 31, 2005 ranged from 0.4% to 13.5% (or 8.1% across all service areas). Medicare Advantage penetration in service areas in other markets has surpassed 40%. In addition, as of December 31, 2005, our share of Medicare Advantage plan enrollees (expressed as a percentage of total Medicare Advantage plan enrollees) in our service areas in our Tennessee, Texas, and Alabama markets was approximately 88%, 47%, and 32%, respectively.

Effective Medical Management. Our medical management efforts are designed primarily for the Medicare Advantage program. For the combined twelve month period ended December 31, 2005, our Medicare MLR was 78.4%. We believe our ability to predict and manage our medical expenses is the result of the following primary factors:

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Analytical Focus We have institutionalized, throughout our management team, a data-driven analytical focus on our operations. We intensively review, on a monthly basis, actuarial analyses of claims data, IBNR claims, medical cost trends and loss ratios, and other relevant data by service area and product. We also assess provider relations on a monthly basis in reliance upon reports prepared by the senior management team for each of our markets. The monthly reviews are attended by senior management of the company and our local markets and allow us to identify and address favorable and adverse trends in a timely manner.

Provider Partnerships Our management team has extensive experience managing providers and provider networks, including independent physician associations such as Renaissance Physician Organization, or RPO. We believe this experience provides us a competitive advantage in structuring our provider contracts and provider relations generally. Our provider networks at December 31, 2005 included over 10,600 physicians and 165 hospitals. We seek providers who have experience in managing the Medicare population. We attempt to partner with our providers by, among other things, aligning physician interests with our interests and the interests of our members by way of incentive compensation and risk-sharing arrangements. These incentive arrangements are 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. Additionally, we internally monitor and evaluate the performance of our providers on a periodic basis to ensure these relationships are successful in meeting their goals and engage our providers directly when appropriate to address performance deficiencies individually or within their networks.

Focus on Promoting Member Wellness and Managing Medical Care Utilization We practice a gatekeeper approach to managing care. Each member selects a primary care physician who coordinates care for that member and, in conjunction with the company, monitors and controls the member s utilization of the network. Although the primary care physician is primarily responsible for managing member utilization and promoting member wellness, we have also implemented comprehensive health services quality management programs to help ensure high quality, cost-effective healthcare for our members, and in particular the chronically ill. We actively manage improvements in beneficiary care through internal and outsourced disease management programs for members with chronic medical conditions. We have also designed case management programs to provide more effective utilization of healthcare services by our members, including through the employment of on-site critical care intensivists, hospitalists, and concurrent review nurses who are trained to know the appropriate times for outpatient care, hospitalization, rehabilitation, or home care, and through partnerships with third party case management specialists. We work closely with our disease and case management partners in a hands-on approach to help ensure the desired outcomes. Our providers are trained and encouraged to utilize our disease and case management programs in an effort to improve clinical and financial outcomes.

Scalable Operating Structure. We have centralized certain functions of our health plans, including claims payment, actuarial review, health risk assessment, and benefit design for operational efficiencies and to facilitate our analytical, data-driven approach to operations. Other functions, including member services, sales and marketing, provider relations, medical management, and financial reporting and analysis, are customized for each of our local service areas. We believe this combination of centralized administrative functions and local service area 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. Additionally, we have designed our centralized and local administrative and information services functions to be scalable to accommodate our growth in existing or new service areas.

Experienced Management Team. Our management team has expertise in the Medicare Advantage segment of the managed care industry. Our present operations team has focused primarily on the operation of Medicare managed care plans since 2000. Prior to joining the company, our operations team managed physician networks and structured risk-sharing relationships among healthcare providers. We believe this experience, including operating and growing Medicare Advantage plans through acquisitions and internal growth, gives us an advantage over our competitors. We also intend to use our independent physician association management experience to further develop our provider

relationships, and independent physician association relationships in particular, through the replication of existing arrangements we have created with independent physician associations in certain of our markets.

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Regulation

Overview

As a managed healthcare company, our operations are and will continue to be subject to substantial federal, state, and local government regulation which will have a broad effect on the operation of our health plans. The laws and regulations affecting our industry generally give state and federal regulatory authorities broad discretion in their exercise of supervisory, regulatory and administrative powers. These laws and regulations are intended primarily for the benefit of the members and providers of the health plans.

Our right to obtain payment from Medicare is subject to compliance with numerous regulations and requirements, many of which are complex, evolving as a result of the MMA and subject to administrative discretion. Moreover, since we are contracting only with the Medicare program to provide coverage for beneficiaries of our Medicare Advantage plans, our Medicare revenues are completely dependent upon the reimbursement levels and coverage determinations in effect from time to time in the Medicare Advantage program.

In addition, in order to operate our Medicare Advantage plans, we must obtain and maintain certificates of authority or license from each state in which we operate. In order to remain certified we generally must demonstrate, among other things, that we have the financial resources necessary to pay our anticipated medical care expenses and the infrastructure needed to account for our costs and otherwise meet applicable licensing requirements. Accordingly, in order to remain qualified for the Medicare Advantage program, it may be necessary for our Medicare Advantage plans to make changes from time to time in their operations, personnel, and services. Although we intend for our Medicare Advantage plans to maintain certification and to continue to participate in those reimbursement programs, there can be no assurance that our Medicare Advantage plans will continue to qualify for participation.

Each of our health plans is also required to report quarterly on its financial performance to the appropriate regulatory agency in the state in which the health plan is licensed. Each plan also undergoes periodic reviews of our quality of care and financial status by the applicable state agencies.

Federal Regulation

Medicare. Medicare is a federally sponsored healthcare plan for persons aged 65 and over, qualifying disabled persons and persons suffering from end-stage renal disease which provides a variety of hospital and medical insurance benefits. We contract with CMS to provide services to Medicare beneficiaries pursuant to the Medicare Advantage program. As a result, we are subject to extensive federal regulations, some of which are described in more detail below. CMS may audit any health plan operating under a Medicare contract to determine the plan s compliance with federal regulations and contractual obligations.

A more complete description of Medicare and the MMA is set forth above under The 2003 Medicare Modernization Act. We are currently monitoring the implementation of the MMA to determine how it will impact our operations throughout 2006 and we will continue to monitor this issue as new regulations are released.

Additionally, the marketing activities of Medicare Advantage plans are strictly regulated by CMS. For example, CMS has oversight over all, and in some cases has imposed advance approval requirements with respect to, marketing materials used by our Medicare Advantage plans, and our sales activities are limited to activities such as conveying information regarding the benefits of preventive care, describing the operations of managed care plans, and providing information about eligibility requirements. Federal law precludes states from imposing additional marketing restrictions on Medicare Advantage plans. States, however, remain free to regulate, and typically do regulate, the marketing activities of plans that enroll commercial beneficiaries.

Fraud and Abuse Laws. The federal anti-kickback statute imposes criminal and civil penalties for paying or receiving remuneration (which includes kickbacks, bribes, and rebates) in connection with any federal healthcare program, including the Medicare program. The law and related regulations have been interpreted to prohibit the payment, solicitation, offering or receipt of any form of remuneration in return for the referral of federal healthcare program patients or any item or service that is reimbursed, in whole or in part, by any federal healthcare program.

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In some of our markets, states have adopted similar anti-kickback provisions, which apply regardless of the source of reimbursement.

With respect to the federal anti-kickback statute, there are two safe harbors addressing certain risk-sharing arrangements. In addition, the Office of the Inspector General has adopted other safe harbors related to managed care arrangements. These safe harbors describe relationships and activities that are deemed not to violate the federal anti-kickback statute. However, failure to satisfy each criterion of an applicable safe harbor does not mean that an arrangement constitutes a violation of the law; rather the arrangement must be analyzed on the basis of its specific facts and circumstances. Business arrangements that do not fall within a safe harbor do create a risk of increased scrutiny by government enforcement authorities. We have attempted to structure our risk-sharing arrangements with providers, the incentives offered by our health plans to Medicare beneficiaries, and the discounts our plans receive from contracting healthcare providers to satisfy the requirements of these safe harbors. There can be no assurance, however, that upon review regulatory authorities will determine that our arrangements do not violate the federal anti-kickback statute.

CMS has promulgated regulations that prohibit health plans with Medicare contracts from including any direct or indirect payment to physicians or other providers as an inducement to reduce or limit medically necessary services to a Medicare beneficiary. These regulations impose disclosure and other requirements relating to physician incentive plans including bonuses or withholdings that could result in a physician being at substantial financial risk as defined in Medicare regulations. Our ability to maintain compliance with these regulations depends, in part, on our receipt of timely and accurate information from our providers. We conduct our operations in an attempt to comply with these regulations; however, we are subject to future audit and review. It is possible that regulatory authorities may challenge our provider arrangements and operations and there can be no assurance that we would prevail if challenged.

Federal False Claims Act. We are subject to a number of laws that regulate the presentation of false claims or the submission of false information to the federal government. For example, the federal False Claims Act provides, in part, that the federal government may bring a lawsuit against any person or entity whom it believes has knowingly presented, or caused to be presented, a false or fraudulent request for payment from the federal government, or who has made a false statement or used a false record to get a claim approved. The federal government has taken the position that claims presented in violation of the federal Anti-Kickback Statute may be considered a violation of the federal False Claims Act. Violations of the False Claims Act are punishable by treble damages and penalties of up to $11,000 per false claim. In addition to suits filed by the government, a special provision under the False Claims Act allows a private individual (e.g., a whistleblower such as a disgruntled former employee, competitor or patient) to bring an action under the False Claims Act on behalf of the government alleging that an entity has defrauded the federal government and permits the whistleblower to share in any settlement or judgment that may result from that lawsuit. Although we strive to operate our business in compliance with all applicable rules and regulations, we may be subject to investigations and lawsuits under the False Claims Act that may be initiated either by the government or a whistleblower. It is not possible to predict the impact such actions may have on our business.

Health Insurance Portability and Accountability Act of 1996. The Health Insurance Portability and Accountability Act of 1996, or HIPAA, imposes requirements relating to a variety of issues that affect our business, including the privacy and security of medical information, limits on exclusions based on preexisting conditions for our plans, guaranteed renewability of healthcare coverage for most employers and individuals and administrative simplification procedures involving the standardization of transactions and the establishment of uniform healthcare provider, payor and employer identifiers. Various federal agencies have issued regulations to implement certain sections of HIPAA.

For example, the Department of Health and Human Services, or DHHS, issued a final rule that establishes the standard data content and format for the electronic submission of claims and other administrative health transactions. Although we believe our operations are compliant with the electronic data standards established by the final rule, to the extent that we submit to Medicare electronic healthcare claims and payment transactions that are deemed not to be in compliance with these standards, payments to us may be delayed or denied. Additionally, DHHS has issued a final privacy rule and final security standards that apply to individually identifiable health information. The primary purposes of the privacy rule are to protect and enhance the rights of consumers by providing them access to their

health information and controlling the inappropriate use of that information, and to

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improve the efficiency and effectiveness of healthcare delivery by creating a national framework for health privacy protection that builds on efforts by states, health systems, individual organizations, and individuals. The final rule for security standards establishes minimum standards for the security of individually identifiable health information that is transmitted or maintained electronically. We will conduct our operations in an attempt to comply with the requirements of the privacy rule and the security standards. There can be no assurance, however, that upon review regulatory authorities will find that we are in compliance with these requirements.

On January 8, 2001, the U.S. Department of Labor s Pension and Welfare Benefits Administration, the IRS and DHHS issued two regulations that provide guidance on the nondiscrimination provisions under HIPAA as they relate to health factors and wellness programs. These provisions prohibit a group health plan or group health insurance issuer from denying an individual eligibility for benefits or charging an individual a higher premium based on a health factor. We do not believe that these regulations will have a material adverse effect on our business.

Employee Retirement Income Security Act of 1974. The provision of services to certain employee health benefit plans is subject to the Employee Retirement Income Security Act of 1974, or ERISA. ERISA regulates certain aspects of the relationships between plans and employer