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.

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 September 30,	Period from January 1, 2005 to February 28,	Period from March 1, 2005 to September 30,	Combined Nine Months Ended September 30,
	2002	2003(1)	2004(2)	2004	2005(3)	2005(3)	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

6

Table of Contents

	Predecessor					HealthSpring, Inc.	
	Year Ended December 31,			Nine Months Ended September 30,	Period from January 1, 2005 to February 28,	Period from March 1, 2005 to September 30,	Combined Nine Months Ended September 30,
	2002	2003(1)	2004(2)	2004	2005(3)	2005(3)	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.

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

8

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

Table of Contents

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

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

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

Table of Contents

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

18

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

Table of Contents

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.

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 a majority of the directors;
- any stockholder wishing to properly bring a matter before a meeting of stockholders must comply with specified procedural and advance notice requirements;
- actions taken by the written consent of our stockholders require the consent of the holders of at least $66^{2}/3$% of our outstanding shares;
- our board of directors will be classified into three classes, with each class serving a staggered three-year term;
- the authorized number of directors may be changed only by resolution of the board of directors;
- our second amended and restated bylaws and certain sections of our amended and restated certificate of incorporation relating to anti-takeover provisions may generally only be amended with the consent of the holders of at least $66^{2}/3$% of our outstanding shares;
- directors may be removed other than at an annual meeting only for cause;

- any vacancy on the board of directors, however the vacancy occurs, may only be filled by the directors; and
- our board of directors has the ability to issue preferred stock without stockholder approval.

Table of Contents

See also, Description of Capital Stock Anti-Takeover Provisions of our Certificate of Incorporation and Bylaws.

Future Sales of Our Common or Preferred Stock Could Lower the Market Price of Our Common Stock.

After this offering, we will have outstanding 57,289,549 shares of common stock. Each of our officers and directors and the holders of substantially all of our common stock, including the selling stockholders, have agreed, subject to specified exceptions, that without the prior written consent of each of Goldman, Sachs & Co. and Citigroup Global Markets Inc., they will not, directly or indirectly, sell, offer, contract to sell, transfer the economic risk of ownership in, make any short sale, pledge or otherwise dispose of any shares of our capital stock or any securities convertible into or exchangeable or exercisable for or any other rights to purchase or acquire our capital stock for a period of 180 days from the date of this prospectus. Each of Goldman, Sachs & Co. and Citigroup Global Markets Inc., may, in their sole discretion, permit early release of shares subject to the lock-up agreements. In addition, pursuant to our amended and restated stockholders agreement, each share of our common stock beneficially owned by our existing stockholders, other than the GTCR Funds, is generally subject to restrictions on transfer, other than certain permitted transfers described in the stockholders agreement.

Assuming the underwriters do not exercise their over-allotment option:

- an aggregate of 36,449,355 shares of our common stock will be available for sale 180 days after the date of this prospectus; and

- 2,040,194 shares will be available for sale on the first anniversary of the date of this prospectus.

For a further description of the lock-up arrangements with our existing stockholders and the eligibility of shares for sale into the public market following this offering, see Shares Eligible for Future Sale Lock-Up Agreements and Underwriting.

Promptly following this offering, we intend to register the shares of common stock that are authorized for issuance under our 2006 equity incentive plan and the shares issuable upon the exercise of options outstanding under our 2005 stock option plan. Once we register these shares, they can be freely sold in the public market upon issuance, subject to the lock-up agreements referred to above, applicable vesting restrictions and the restrictions imposed on our affiliates under Rule 144. Additionally, the shares issued pursuant to restricted stock purchase agreements described elsewhere in this prospectus will be eligible for sale pursuant to Rule 701, subject to the 180 day lock-up period described above and applicable transfer restrictions.

In addition, after this offering, subject to specified conditions and limitations, certain of our existing stockholders will be entitled to registration rights pursuant to a registration rights agreement as further described under Description of Capital Stock Registration Rights. In the future, we may issue additional shares, including options, warrants, preferred stock, or other convertible securities, to our employees, directors, consultants, business associates, acquired entities and/or their equityholders, or other strategic partners, or in follow-on public and/or private offerings to raise additional capital or for other purposes. Due to these factors, sales of a substantial number of shares of our common stock in the public market could occur at any time. These sales could reduce the market price of our common stock.

If You Purchase Our Common Stock in This Offering, You Will Incur Immediate and Substantial Dilution in the Book Value of Your Shares.

If you purchase shares in this offering, the value of your shares based on our actual book value will immediately be less than the offering price you paid. This reduction in the value of your equity is known as dilution. This dilution occurs in large part because our earlier investors paid substantially less than the initial public offering price when they purchased their shares. For example, investors

Table of Contents

purchasing shares in the offering will have contributed approximately 46.9% of the total amount of our equity funding since incorporation and will own approximately 32.8% of the shares outstanding (including shares sold by the GTCR Funds comprising 14.3% of the shares outstanding after this offering). Investors purchasing common stock in this offering will incur immediate dilution of $18.70 per share of common stock as further described in the section of this prospectus entitled Dilution. As a result of this dilution, investors purchasing stock in this offering may receive significantly less than the purchase price paid in this offering in the event of a liquidation. Investors will incur additional dilution upon the exercise of stock options or other equity-based awards under our equity incentive plans. In addition, if we issue additional shares, including options, warrants, preferred stock or other convertible securities, in the future to acquired entities and their equityholders, our business associates, or other strategic partners or in follow-on public and private offerings, the newly issued shares will further dilute your percentage ownership of our company.

Table of Contents

SPECIAL NOTE REGARDING FORWARD-LOOKING STATEMENTS

This prospectus contains forward-looking statements. The forward-looking statements are contained primarily in the sections entitled Prospectus Summary, Risk Factors, Management s Discussion and Analysis of Financial Condition and Results of Operations and Business. These statements involve known and unknown risks, uncertainties and other 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. In some cases, you can identify forward-looking statements by terms including anticipates, believes, could, estimates, expects, intends, may, plans, pote projects, should, will, would, and similar expressions intended to identify 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.

Governmental action or business conditions could result in premium revenues not increasing to offset increases in medical expenses and other operating expenses. Once set, premiums are generally fixed for one year periods and, accordingly, unanticipated costs during these periods cannot be recovered through higher premiums. Furthermore, if we are unable to accurately estimate incurred but not reported medical expenses, our profitability may be affected. Due to these and the factors and risks described above, no assurance can be given with respect to our future premium levels or our ability to control our future medical expenses.

Additionally, from time to time, legislative and regulatory proposals have been made at the federal and state government levels related to the healthcare system, including but not limited to limitations on managed care organizations, including benefit mandates, and reform of the Medicare program. Such legislative and regulatory action could have the effect of reducing the premiums paid to us pursuant to the Medicare program or increasing our medical expenses. We are unable to predict the specific content of any future legislation, action or regulation that may be enacted or when any such future legislation or regulation will be adopted. Therefore, we cannot predict accurately the effect of such future legislation, action or regulation on our business.

Our results of operations and projections of future earnings also depend in large part on accurately predicting and effectively managing medical expenses and other operating expenses. A variety of factors may in the future affect our ability to control our medical expenses and other operating expenses, including:

competition;

changes in healthcare practices;

changes in laws and regulations or interpretations thereof;

the expiration, cancellation or suspension of our contracts by CMS;

the loss of our federal or state certifications to operate our health plans;

inflation;

provider and facility contract changes;

new technologies;

unforeseen expenses related to providing prescription drug benefits;

the loss of members who choose stand-alone prescription drug plans in 2006;

our ability to successfully implement our disease management and utilization management programs;

- major epidemics; and
- disasters and numerous other factors affecting the delivery and cost of healthcare, including major healthcare providers inability to maintain their operations.

We discuss many of the foregoing risks in this prospectus in greater detail under the heading Risk Factors. Given these uncertainties, you should not place undue reliance on these forward-looking statements. Also, forward-looking statements represent our estimates and assumptions only as of the date of this prospectus. You should read this prospectus and the documents that we reference in this prospectus and have filed as exhibits to the registration statement of which this prospectus is a part completely and with the understanding that our actual future results may be materially different from what we expect. Except as required by law, we assume no obligation to update these forward-looking statements publicly, or to update the reasons actual results could differ materially from those anticipated in these forward-looking statements, even if new information becomes available in the future.

Table of Contents

RECAPITALIZATION

HealthSpring, Inc. was formed in October 2004 in connection with a recapitalization transaction, which was accounted for using the purchase method, involving the company, our predecessor NewQuest, LLC, its members, GTCR Golder Rauner II, L.L.C., a private equity firm, and its related funds, or the GTCR Funds, and certain other investors and lenders. The recapitalization was completed in March 2005. Prior to the recapitalization, NewQuest, LLC was owned 43.9% by officers and employees of NewQuest, LLC, 38.2% by non-employee directors of NewQuest, LLC, and 17.9% by outside investors.

In connection with the recapitalization, the company, NewQuest, LLC, the members of NewQuest, LLC, the GTCR Funds, and certain other investors entered into a purchase and exchange agreement and other related agreements pursuant to which the GTCR Funds and other investors purchased an aggregate of 136,072 shares of our preferred stock and 18,237,587 shares of our common stock for an aggregate purchase price of $139.7 million. The members of NewQuest, LLC exchanged their ownership interests in NewQuest, LLC for an aggregate of $295.4 million in cash (including $17.2 million placed in escrow to secure contingent post-closing indemnification liabilities), 91,082 shares of our preferred stock and 12,207,631 shares of our common stock. In addition, upon the closing of the recapitalization, we issued an aggregate of 1,286,250 shares of restricted common stock to our employees for an aggregate purchase price of $257,250. We used the proceeds from the sale of preferred stock and common stock and $200 million of borrowings under our senior credit facility and senior subordinated notes to fund the cash payments to the members of NewQuest, LLC and to pay expenses and make other payments relating to the transaction. Following the recapitalization, we were owned 55.1% by the GTCR Funds, 28.7% by our executive officers and employees, and 16.2% by outside investors, including one of our non-employee directors. See Certain Relationships and Related Transactions for additional information with respect to the recapitalization.

Prior to the recapitalization, approximately 15% of the ownership interests in our Tennessee subsidiaries, HealthSpring Management, Inc. and HealthSpring USA, LLC, and approximately 27% of the membership interests of our Texas HMO subsidiary, Texas HealthSpring, LLC, were owned by minority investors. As part of the recapitalization, we purchased all of the minority interests in our Tennessee subsidiaries for an aggregate consideration of approximately $27.5 million and a portion of the membership interests held by the minority investors in Texas HealthSpring, LLC for aggregate consideration of approximately $16.8 million. Following the purchase, the outside investors in Texas HealthSpring, LLC owned an approximately 9% ownership interest. In June 2005, Texas HealthSpring, LLC completed a strategic private placement pursuant to which it issued new membership interests to existing and new investors, primarily physicians affiliated with RPO. Following this private placement, the minority investors owned an approximately 15.9% interest in Texas HealthSpring, LLC, which interest will be automatically exchanged, without additional consideration, for shares of our common stock immediately prior to the completion of this offering in accordance with the organizational documents of Texas HealthSpring, LLC.

Table of Contents

USE OF PROCEEDS

We estimate that we will receive net proceeds from the sale of shares of our common stock in this offering of approximately $188.8 million, based upon the initial public offering price of $19.50 per share and after deducting underwriting discounts and estimated offering expenses payable by us. We will not receive any of the proceeds from the sale of common stock by the selling stockholders.

We will use all of the $188.8 million of the net proceeds from this offering, together with approximately $1.2 million in available cash, to repay all of our outstanding debt and accrued and unpaid interest and a related prepayment premium. Our outstanding indebtedness was incurred to fund a portion of the amounts paid to the equity holders of our predecessor and to pay expenses and make other payments in connection with the recapitalization. Our outstanding indebtedness consists of:

- approximately $152.6 million principal amount under a term loan facility that bears interest at a variable rate (7.53% as of December 31, 2005) and has a final maturity of March 2011, plus accrued and unpaid interest of approximately $31,911 at December 31, 2005; and

- approximately $35.0 million original principal amount, which had accreted at December 31, 2005 to $35.9 million, of our senior subordinated notes that bear interest at a rate of 15% per annum (12% of which is payable in cash and 3% of which is accrued quarterly and added to the principal amount outstanding) and matures in March 2012, plus accrued and unpaid interest of approximately $370,018 at December 31, 2005 and a prepayment premium of approximately $1.0 million.

DIVIDEND POLICY

We have never declared or paid any cash dividends on our common stock. Our predecessor, which was a pass-through entity for tax purposes, made distributions to its members in the aggregate amounts of $19.5 million and $10.9 million in 2004 and 2003, respectively. We currently intend to retain any future earnings to fund the operation, development, and expansion of our business, and therefore we do not anticipate paying cash dividends in the foreseeable future. Furthermore, our revolving credit facility will, in the event any amounts are then outstanding thereunder, restrict our ability to declare cash dividends on our common stock. Our ability to pay dividends is also dependent on the availability of cash dividends from our regulated HMO subsidiaries, which are restricted by the laws of the states in which we operate, as well as the requirements of CMS relating to the operations of our Medicare Advantage health plans. At September 30, 2005, $188.4 million out of an aggregate of $205.8 million of our cash, cash equivalents, investment securities, and restricted investments were held by our HMO subsidiaries and subject to these distribution restrictions. Any future determination to declare and pay dividends will be at the discretion of our board of directors, subject to compliance with applicable law and the other limitations described above.

Table of Contents

CAPITALIZATION

The following table sets forth our capitalization as of September 30, 2005:

on an actual basis; and

as adjusted to reflect the following events as if they had occurred on September 30, 2005:

(i) the conversion of all outstanding shares of our preferred stock and accrued and unpaid dividends thereon into 12,552,905 shares of our common stock (see Certain Relationships and Related Transactions Terms of Preferred Stock);

(ii) the exchange of all membership units of one of our HMO subsidiaries, Texas HealthSpring, LLC, that are not owned by us for 2,040,194 shares of our common stock; and

(iii) the issuance and sale of 10,600,000 shares of our common stock by us in this offering, at the initial public offering price of $19.50 per share, less estimated underwriting discounts and offering expenses payable by us, together with the application of the net proceeds from this offering to repay our outstanding indebtedness as described in Use of Proceeds.

You should read the information below in conjunction with the financial statements and the related notes thereto and Management s Discussion and Analysis of Financial Condition and Results of Operations included elsewhere in this prospectus.

	As of September 30, 2005	
	Actual	As Adjusted
	(Dollars in thousands)	
Cash and cash equivalents	$ 150,408	$ 149,253
Debt:		
Senior term loan(1)	156,750	
Senior revolving credit facility(1)		
Senior subordinated notes(1)	35,628	
Total long-term debt	192,378	
Stockholders equity:		
Redeemable convertible preferred stock, par value $.01 per share:		
1,000,000 shares authorized, 227,154 shares issued and outstanding, actual	2	
Preferred stock, par value $.01 per share:		
5,000,000 shares authorized, as adjusted, no shares issued and outstanding, as adjusted		
Common stock, par value $.01 per share:		
74,000,000 shares authorized, 32,283,968 shares issued and outstanding, actual, and 180,000,000 shares authorized and 57,289,549 shares issued and outstanding, as adjusted	323	573
Additional paid-in capital	249,451	477,730

Unearned compensation		(2,177)		(2,177)
Retained earnings		7,803		7,803
Total stockholders equity		255,402		483,929
Total capitalization	$	447,780	$	483,929

(1) We will use the net proceeds of this offering, together with available cash, to repay all amounts outstanding under the term loan portion of our senior secured credit facility and to redeem our senior subordinated notes. Following this offering, our senior secured revolving credit facility will remain in effect.

Table of Contents

The information in the table excludes:

225,000 shares of common stock issuable upon exercise of options issued and outstanding at September 30, 2005 under our 2005 stock option plan, at a weighted average exercise price of $2.45 per share; and

an aggregate of 2,065,500 shares of common stock issuable upon exercise of options awarded, effective as of the completion of this offering, at the initial public offering price and 4,172,000 shares reserved for future issuance under our 2006 equity incentive plan.

Table of Contents

DILUTION

Our net tangible book value as of September 30, 2005 was a deficit of $156.3 million, or $4.84 per share of common stock. Net tangible book value per share represents the amount of our total tangible assets less the amount of our total liabilities, divided by the number of shares of common stock outstanding at September 30, 2005, prior to this offering. Dilution in net tangible book value per share represents the difference between the amount per share paid by investors in this offering and the pro forma, as adjusted net tangible book value per share of our common stock immediately after this offering.

After giving effect to our sale of the 10,600,000 shares of common stock offered by us in this offering (after deducting the underwriting discounts and estimated offering expenses payable by us), based upon the initial public offering price of $19.50 per share, our pro forma, as adjusted net tangible book value as of September 30, 2005 would have been approximately $46.1 million, or $0.80 per share of common stock. This represents an immediate increase in pro forma, as adjusted net tangible book value to our existing stockholders of $5.64 per share and an immediate dilution to new investors in this offering of $18.70 per share. The following table illustrates this per share dilution to new investors:

Assumed initial public offering price per share		$ 19.50
Net tangible book value per share as of September 30, 2005	(4.84)	
Increase per share attributable to new investors	5.64	
Pro forma, as adjusted net tangible book value per share after this offering		0.80
Dilution per share to new investors		$ 18.70

The following table summarizes, as of September 30, 2005, on a pro forma, as adjusted basis, the differences between our existing stockholders and new investors in this offering with respect to the total number of shares of common stock purchased from us, the aggregate cash consideration paid or deemed paid to us, and the average price per share paid or deemed paid. The calculation below is based on the initial public offering price of $19.50 per share, before deducting estimated underwriting and offering expenses payable by us:

	Shares Purchased		Total Consideration		Average Price Per Share
	Number	Percent	Amount	Percent	
Existing stockholders	46,689,549	81.5%	$ 233,610,794	53.1%	$ 5.00
New investors	10,600,000	18.5	206,700,000	46.9	19.50
Total	57,289,549	100.0%	$ 440,310,794	100.0%	

The existing stockholders amounts in the table above assumes no exercise of outstanding stock options at September 30, 2005 and therefore excludes 225,000 shares of common stock issuable upon exercise of options issued under our 2005 stock option plan, at a weighted average exercise price of $2.45 per share.

The foregoing table also does not give effect to the 2,065,500 shares of our common stock issuable upon exercise of options awarded, effective as of the completion of this offering, at the initial public offering price and the 4,172,000 shares reserved for future issuance under our 2006 equity incentive plan. In addition, if we grant options, warrants, preferred stock, or other convertible securities or rights to purchase our common stock in the future with exercise prices below the initial public offering price, new investors will incur additional dilution upon exercise of such securities or rights.

Table of Contents

SELECTED FINANCIAL DATA AND OTHER INFORMATION

The following tables present selected historical financial data and other information for the company and its predecessor, NewQuest, LLC. We derived the selected historical statement of income, cash flows, and balance sheet data as of and for the years ended December 31, 2001, 2002, 2003, and 2004 from the audited consolidated financial statements of NewQuest, LLC. The selected historical statement of income, cash flows, and balance sheet data for NewQuest, LLC as of and for the year ended December 31, 2000 are derived from the unaudited consolidated financial statements of NewQuest, LLC. The audited consolidated financial statements and the related notes to the audited consolidated financial statements of NewQuest, LLC as of and for the years ended December 31, 2002, 2003, and 2004, together with the related report of our independent registered public accounting firm are included elsewhere in this prospectus. We derived the selected statement of income, cash flows, and balance sheet data as of and for the nine months ended September 30, 2004 and the period from January 1, 2005 to February 28, 2005 from the unaudited consolidated financial statements of NewQuest, LLC. We derived the selected statement of income, cash flows, and balance sheet data as of and for the period from March 1, 2005 (the effective date of the recapitalization of NewQuest, LLC) to September 30, 2005 from the unaudited consolidated financial statements of the company. The unaudited consolidated financial statements and the related notes to the unaudited consolidated financial statements of NewQuest, LLC as of and for the nine months ended September 30, 2004 and the period from January 1, 2005 to February 28, 2005, and for the company for the period from March 1, 2005 to September 30, 2005, are included elsewhere in this prospectus.

The selected consolidated financial data and other information set forth below should be read in conjunction with the consolidated financial statements included in this prospectus and the related notes and Management s Discussion and Analysis of Financial Condition and Results of Operations.

Table of Contents

	Predecessor							HealthSpring, Inc.	
	Year Ended December 31,					Nine Months Ended September 30,	Period from January 1, 2005 to February 28,	Period from March 1, 2005 to September 30,	Combi Nine Mont Ende Septemb
	2000(1)	2001(2)	2002(3)	2003(4)	2004(5)	2004	2005(6)	2005(6)	2005(
	(Dollars in thousands, except share and unit data)								
ement ncome n:									
enue:									
nium:									
dicare miums	$ (8)	$ (8)	$ (8)	$ 240,037	$ 433,729	$ 314,358	$ 94,764	$ 403,212	$ 497,9
mmercial miums	(8)	(8)	(8)	120,877	146,318	111,499	20,704	73,857	94,5
otal emiums			24,939	360,914	580,047	425,857	115,468	477,069	592,5
revenue	184	3,976	1,099	11,054	17,919	13,508	3,461	12,018	15,4
stment me		43	78	695	1,449	821	461	2,224	2,6
otal venue	184	4,019	26,116	372,663	599,415	440,186	119,390	491,311	610,7
enses:									
ical ense:									
dicare ense	(8)	(8)	(8)	187,368	338,632	243,646	74,531	315,776	390,3
mmercial ense	(8)	(8)	(8)	104,164	124,743	95,422	16,312	65,437	81,7
otal edical xpense			12,631	291,532	463,375	339,068	90,843	381,213	472,0
ng, eral and inistrative	155	4,921	11,133	50,576	68,868	48,953	14,667	61,577	76,2
nsaction ense							6,941	1,700	8,6
ntom k					24,200				

pensation									
reciation rtization	80	347	275	2,361	3,210	2,352	315	4,782	5,(
rest		10	25	256	214	158	42	10,150	10,1
otal perating xpenses	235	5,278	24,064	344,725	559,867	390,531	112,808	459,422	572,2
ty in s) ings of onsolidated ates	(593)	7,855	4,148	2,058	234	192		30	
on ndment			4,170						
ss) ome ore ority rest and ome es	(644)	6,596	10,370	29,996	39,782	49,847	6,582	31,919	38,5
ority est		(1,050)	(1,315)	(5,519)	(6,272)	(5,098)	(1,248)	(1,218)	(2,4
ss) ome ore ome es	(644)	5,546	9,055	24,477	33,510	44,749	5,334	30,701	36,0
me tax ense			363	5,417	9,193	7,076	2,628	12,139	14,7
(loss) ome ore ferred dends	(644)	5,546	8,692	19,060	24,317	37,673	2,706	18,562	21,2
erred dends								10,759	10,7
(loss) ome ilable to mbers or nmon ckholders	$ (644)	$ 5,546	$ 8,692	$ 19,060	$ 24,317	37,673	$ 2,706	$ 7,803	$ 10,5

(loss) ome per :													
sic	$	(0.46)	$	1.36	$	2.13	$	4.67	$	5.31	$	8.23	$ 0.55
uted	$	(0.46)	$	1.36	$	2.13	$	4.67	$	5.31	$	8.23	$ 0.55
ighted rage s standing:													
sic		1,391,609		4,078,176		4,078,176		4,078,176		4,578,176		4,578,176	4,884,176
uted		1,391,609		4,078,176		4,078,176		4,078,176		4,578,176		4,578,176	4,884,176

33

Table of Contents

	Predecessor							HealthSpring, Inc.	
	Year Ended December 31,					Nine Months Ended September 30,	Period from January 1, 2005 to February 28,	Period from March 1, 2005 to September 30,	Combined Nine Months Ended September
	2000(1)	2001(2)	2002(3)	2003(4)	2004(5)	2004	2005(6)	2005(6)	2005(7)
	(Dollars in thousands, except share and unit data)								
t ome r mmon are ailable mmon ockholders:									
asic	$	$	$	$	$	$	$	$ 0.24	$
luted								$ 0.24	
mmon ares tstanding:									
asic								32,161,574	
luted								32,161,574	
sh ow ta:									
pital penditures	422	46	190	3,198	2,512	2,558	149	2,026	2,175
sh ovided (used :									
perating ctivities	(1,340)	(488)	6,569	63,392	24,665	5,176	14,964	99,193	114,157
vesting ctivities	(1,693)	(46)	(6,123)	42,647	(34,615)	(39,207)	(5,469)	(277,399)(9)	(282,868
nancing ctivities	3,928	250	5,748	(11,750)	(23,311)	(23,060)	(888)	328,614(9)	327,726

lance eet ta (at riod d):									
sh and sh uivalents	895	612	6,806	101,095	67,834	44,004	76,441	150,408	150,408
tal sets	2,757	9,941	37,559	132,420	142,674	118,155	157,350	646,131	646,131
tal g-term ot, luding rrent aturities			4,958	6,175	5,475	5,650	5,358	192,378	192,378
embers / ckholders uity	2,693	8,515	14,504	22,969	55,435	48,013	59,456	255,402	255,402
erating atistics:									
edical s ratio edicare(10)	(8)	(8)	(8)	78.06%	78.07%	77.51%	78.65%	78.32%	78.38
edical s ratio mmercial(10)	(8)	(8)	(8)	86.17%	85.25%	85.58%	78.79%	88.60%	86.45
lling, neral d ministrative pense io(11)	84.04%	122.44%	42.63%	13.57%	11.49%	11.12%	12.28%	12.53%	12.48
embers edicare(12)			33,560	47,899	63,792	59,529	69,236	93,181	93,181
embers mmercial(12)			53,605	54,280	48,380	50,857	40,523	41,937	41,937

(1) The unaudited consolidated financial statements for 2000 include the accounts and results of operations of NewQuest, LLC, its 85% owned subsidiary GulfQuest, LLC, and its 84.375% owned subsidiary TennQuest Health Solutions, LLC, or TennQuest. As of December 31, 2000, TennQuest owned 50% of the outstanding stock in HealthSpring Management, Inc., or HSMI, and HSMI owned 100% of HealthSpring of Tennessee, Inc., or HTI. The company accounted for its ownership interest in HSMI under the equity method of accounting.

(2) On December 21, 2001, the minority shareholders of GulfQuest converted their 15% interest in GulfQuest into NewQuest, LLC membership units.

(3) In November, 2002, NewQuest, LLC acquired The Oath A Health Plan for Alabama, Inc., subsequently renamed HealthSpring of Alabama, Inc., an Alabama for-profit HMO.

(4) 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 HTI s operations 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.

(5) 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.

(6) 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 approximately $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 which 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.

(7) 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 GAAP.

(8) Premium revenues and medical expense are reported in total only and are not separated into Medicare and commercial for 2000, 2001, and 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 2000, 2001, and 2002.

(9) 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.

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

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

(12) At end of each period presented. Data not available for 2000 and 2001.

Table of Contents

MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

You should read the following discussion and analysis in conjunction with our financial statements and related notes included elsewhere in this prospectus. This discussion contains forward-looking statements based on our current expectations that by their nature involve risks and uncertainties. Our actual results and the timing of selected events could differ materially from those anticipated in these forward-looking statements. Moreover, past financial and operating performance are not necessarily reliable indicators of future performance and you are cautioned in using our historical results to anticipate future results or to predict future trends. In evaluating any forward-looking statement, you should specifically consider the information set forth under the captions Risk Factors and Special Note Regarding Forward-Looking Statements as well as other cautionary statements contained elsewhere in this prospectus, including the matters discussed in Critical Accounting Policies and Estimates below.

Overview

We are a managed care organization that focuses primarily on Medicare, 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 CMS. We currently own and operate Medicare health plans in Tennessee, Texas, Alabama, Illinois, and Mississippi. Although we concentrate on Medicare Advantage plans, an alternative to traditional fee-for-service Medicare, we also utilize our infrastructure and provider networks in Tennessee and Alabama to offer commercial health plans to individuals and employer groups. For the combined nine months ended September 30, 2005, approximately 81.5% of our total revenue consisted of premiums we received from CMS pursuant to our Medicare Advantage contracts.

We operate our business through our subsidiaries. In general, we have a licensed HMO subsidiary in each state in which we do business, which is regulated by the relevant state department of insurance. We also typically have nonregulated management subsidiaries in each of our geographic markets that contract with our HMO subsidiaries for management and other administrative services, including financial administration and analysis, credentialing, personnel, claims processing, utilization management, risk management, quality management, customer service, insurance processing, contract negotiation, provider relations, and reporting and analysis. Over our history, these subsidiaries have been accounted for under the equity method or consolidated depending, generally, on the level of ownership by, and control position of, our predecessor, the ultimate parent entity prior to the recapitalization.

In Tennessee, from the commencement of our operations in September 2000 until March 31, 2003, we owned, indirectly, a 50% interest in our Tennessee HMO and management subsidiaries and accounted for these subsidiaries using the equity method. On April 1, 2003, we acquired an additional 33% interest and from the acquisition date consolidated the operations of these subsidiaries for accounting purposes. On December 19, 2003, we increased our ownership interest of the Tennessee subsidiaries to approximately 85%, which was our level of ownership immediately preceding the recapitalization on March 1, 2005. Concurrently with the recapitalization, we acquired the remaining minority interest in the Tennessee HMO. We acquired our Alabama HMO subsidiary in November 2002. In Texas, although we have had, and will continue to have until the completion of this offering, minority ownership interests in our Texas HMO subsidiary, we have accounted for our Texas operations on a consolidated basis for all periods presented herein.

Table of Contents

Our primary source of revenue is monthly premium payments we receive based on membership enrolled in our managed care plans. The following table summarizes our Medicare Advantage and commercial plan membership, by state, as of the dates indicated.

	December 31,			September 30,	
	2002	**2003**	**2004**	**2004**	**2005**
Medicare Advantage Membership					
Tennessee	22,978	25,772	29,862	28,835	39,812
Texas	7,718	15,637	21,221	19,397	28,700
Alabama	2,864	6,490	12,709	11,297	21,521
Illinois					2,915
Mississippi(1)					233
Total	33,560	47,899	63,792	59,529	93,181
Commercial Membership(2)					
Tennessee	30,637	32,668	32,139	32,621	29,658
Alabama	22,968	21,612	16,241	18,236	12,279
Total	53,605	54,280	48,380	50,857	41,937

(1) We commenced enrollment efforts in Mississippi effective July 1, 2005.

(2) 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.

As a result of the MMA reforms, and particularly as a result of the prescription drug coverage requirements under Medicare Part D that became effective January 1, 2006, we expect Medicare Advantage plan membership penetration in our markets generally and enrollment in our Medicare plans specifically to increase. We expect our Medicare PMPM premiums to increase in 2006 as a result of drug coverage premiums as well as annual rate increases. We also expect our Medicare medical loss ratios, or MLRs, to increase as we take into account additional costs related to prescription drugs. In addition, we expect a substantial increase in our Medicare membership in 2006 attributable to new enrollment in our PDPs. Approximately 90,000 beneficiaries have enrolled in our PDPs effective January 1, 2006, substantially all of whom are auto-enrolled dual-eligible beneficiaries.

The Recapitalization

HealthSpring, Inc. was formed in October 2004 in connection with a recapitalization transaction, which was accounted for using the purchase method, involving our predecessor, NewQuest, LLC, its members, the GTCR Funds, and certain other investors and lenders. The recapitalization was completed on March 1, 2005. Prior to the recapitalization, NewQuest, LLC was owned 43.9% by our officers and employees, 38.2% by non-management directors of NewQuest, LLC, and 17.9% by outside investors.

In connection with the recapitalization, the company, NewQuest, LLC, its members, the GTCR Funds, and certain other investors entered into a purchase and exchange agreement and other related agreements pursuant to which the GTCR Funds and certain other investors purchased an aggregate of 136,072 shares of our preferred stock and 18,237,587 shares of our common stock for an aggregate purchase price of $139.7 million. The members of NewQuest, LLC exchanged or sold their ownership interests in NewQuest, LLC for an aggregate of $295.4 million in

cash (including $17.2 million placed in escrow to secure contingent post-closing indemnification liabilities), 91,082 shares of our preferred stock, and 12,207,631 shares of our common stock. In addition, upon the closing of the recapitalization, the company issued an aggregate of 1,286,250 shares of restricted common stock to employees of the company for an aggregate purchase price of $257,250. The company used the proceeds from the sale of preferred and common stock and $200 million of borrowings under our senior credit facility and senior subordinated notes to fund the cash payments

Table of Contents

to the members of NewQuest, LLC and to pay expenses and other payments relating to the transaction. Immediately following the recapitalization, the company was owned 55.1% by the GTCR Funds, 28.7% by our executive officers and employees, and 16.2% by outside investors, including one of our non-employee directors.

Prior to the recapitalization, approximately 15% of the ownership interests in two of our Tennessee management subsidiaries and approximately 27% of the membership interests of our Texas HMO subsidiary, Texas HealthSpring, LLC, were owned by outside investors. Contemporaneously with the recapitalization, we purchased all of the minority interests in our Tennessee subsidiaries for an aggregate consideration of approximately $27.5 million and a portion of the membership interests held by the minority investors in Texas HealthSpring, LLC for aggregate consideration of approximately $16.8 million. Following the purchase, the outside investors in Texas HealthSpring, LLC owned an approximately 9% ownership interest. In June 2005, Texas HealthSpring completed a private placement pursuant to which it issued new membership interests to existing and new investors, primarily physicians affiliated with RPO, for net proceeds of $7.7 million. Following this private placement, and as of September 30, 2005, the outside investors owned an approximately 15.9% interest in Texas HealthSpring, LLC, which interest will be automatically exchanged, without additional consideration, for shares of our common stock immediately prior to the completion of this offering.

The recapitalization was accounted for using the purchase method of accounting in accordance with Statement of Financial Accounting Standards, or SFAS, No. 141, *Business Combinations*. 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, the company incurred $6.9 million of transaction costs which were expensed during the two-month period ended February 28, 2005 and $1.7 million which were expensed during the seven-month period ended September 30, 2005. As a result of the recapitalization, the company acquired $114.7 million of net assets, including $91.2 million of identifiable intangible assets, and goodwill of approximately $323.8 million. Of the $91.2 million of identifiable intangible assets we recorded, $24.5 million has an indefinite life, and the remaining $66.7 million is being amortized over periods ranging from 5 to 15 years.

Basis of Presentation

HealthSpring as it existed prior to the March 1, 2005 recapitalization is sometimes referred to as predecessor. For purposes of comparing our 2005 nine-month results with the comparable 2004 period, we have combined the results of operations of the predecessor from January 1, 2005 through February 28, 2005 and of the company for March 1, 2005 through September 30, 2005. This combined presentation is not in accordance with GAAP; however, we believe it is useful in analyzing and comparing certain of our operating trends from September 30, 2004 to September 30, 2005.

Results of Operations

Revenue

General. Our revenue consists primarily of (i) premium revenue we generate from our Medicare and commercial lines of business; (ii) fee revenue we receive for management and administrative services provided to independent physician associations, health plans, and self-insured employers, and for access to our provider networks; and (iii) investment income.

Premium Revenue. Our Medicare and commercial lines of business include all premium revenue we receive in our health plans. Our Medicare Advantage contracts entitle us to premium payments from CMS, on behalf of each Medicare beneficiary enrolled in our plans, generally on a per member per month, or PMPM, basis. In our commercial HMOs, we receive a monthly payment from or on behalf of each enrolled member. In both our commercial and Medicare plans we recognize premium revenue during the month in which the company is obligated to provide services

to an enrolled member. Premiums we receive in advance of that date are recorded as deferred revenue.

Premiums for our Medicare and commercial products are generally fixed by contract in advance of the period during which health care is covered. Each of our Medicare Advantage plans submits rate proposals to CMS, generally by county or service area, in June for each Medicare Advantage product that will be offered beginning January 1 of the subsequent year in accordance with the new competitive bidding process under the MMA. Retroactive rate adjustments are made periodically with respect to each of our Medicare Advantage plans based on the aggregate health status and risk scores of our plan populations. Our commercial premiums are generally fixed for the plan year, in most cases beginning January 1.

Fee Revenue. Fee revenue includes amounts paid to us for management services provided to independent physician associations and health plans. Our management subsidiaries typically generate this fee revenue on one of three principal bases: (1) as a percentage of revenue collected by the relevant health plan; (2) as a fixed PMPM payment or percentage of revenue for members serviced by the relevant independent physician association; or (3) as fees we receive for offering access to our provider networks and for administrative services we offer to self-insured employers. Fee revenue is recognized in the month in which services are provided. In addition, pursuant to certain of our management agreements with independent physician associations, we receive fees based on a share of the profits of the independent physician associations. To the extent these fees relate to members of our HMO subsidiaries, the fees are recognized as a credit to medical expense when we can readily determine that such fees have been earned, which determination is typically made on a monthly basis.

Investment Income. Investment income consists of interest income and gross realized gains and losses incurred on short term available for sale and long term held to maturity investments.

Expenses

Medical Expense. Our largest expense is the cost of medical services we arrange for our members, or medical expenses. Medical expenses for our Medicare Advantage and commercial plans primarily consist of payments to physicians, hospitals, and other health care providers for services provided to our Medicare Advantage and commercial members. We generally pay our providers on one of three bases: (1) fee-for-service contracts based on negotiated fee schedules; (2) capitated arrangements, generally on a fixed PMPM payment basis, whereby the provider generally assumes the medical expense risk; and (3) risk-sharing arrangements, whereby we advance a capitated PMPM amount and share the risk of the medical costs of our members, professional, institutional, or both, with the provider based on actual experience as measured against pre-determined sharing ratios.

One of our primary tools for managing our business and measuring our profitability is our medical loss ratio, or MLR, the ratio of our medical expenses to the premiums we receive. Changes in the MLR from period to period result from, among other things, changes in Medicare funding or commercial premiums, changes in benefits offered by our plans, our ability to manage medical expenses, and changes in accounting estimates related to incurred but not reported, or IBNR, claims. We use MLRs both to monitor our management of medical expenses and to make various business decisions, including what plans or benefits to offer, what geographic areas to enter or exit, and our selection of healthcare providers. We analyze and evaluate our Medicare and commercial MLRs separately.

Table of Contents

Percentage Comparisons

The following table sets forth the consolidated and combined statements of income data expressed as a percentage of revenues for each period indicated.

	Year Ended December 31,		Nine Months Ended September 30,	Combined Nine Months Ended September 30,
	2003	2004	2004	2005
Revenue:				
Premium:				
Medicare premiums	64.4%	72.4%	71.4%	81.5%
Commercial premiums	32.4	24.4	25.3	15.5
Total premiums	96.8	96.8	96.7	97.0
Fee revenue	3.0	3.0	3.1	2.5
Investment income	0.2	0.2	0.2	0.4
Total Revenue	100.0	100.0	100.0	100.0
Expenses:				
Medical expense	78.2	77.3	77.0	77.3
Selling, general and administrative expense	13.6	11.5	11.1	12.5
Transaction expense				1.4
Phantom stock compensation		4.0		
Depreciation and amortization expense	0.6	0.6	0.6	0.8
Interest expense	0.1			1.7
Total expenses	92.5	93.4	88.7	93.7
Equity in earnings of unconsolidated affiliates	0.6			
Income before minority interest and income taxes	8.1	6.6	11.3	6.3
Minority interest	(1.5)	(1.0)	(1.2)	(0.4)
Income before income taxes	6.6	5.6	10.1	5.9
Income tax expense	1.5	1.5	1.5	2.4
Net income	5.1	4.1	8.6	3.5
Net income available to members or common stockholders	5.1%	4.1%	8.6%	1.7%

Comparison of the Combined Nine Month Period Ended September 30, 2005 to the Nine Month Period Ended September 30, 2004

Membership

Our Medicare Advantage membership increased by 56.5% to 93,181 members at September 30, 2005 as compared to 59,529 members at September 30, 2004. Substantially all of this increase was attributable

to growth in membership in our existing core markets in Tennessee, Texas, and Alabama, through increased penetration in existing service areas and geographic expansion into new counties contiguous to existing service areas. Our commercial HMO membership declined by 17.5% over the same period, from 50,857 to 41,937, primarily as a result of the decision to increase premiums to maintain our commercial margins and the discontinuance of certain unprofitable customer and provider relationships in Alabama and Tennessee.

Table of Contents

Revenue

Total revenue was $610.7 million in the first nine months of 2005 as compared with $440.2 million for the comparable period of 2004, representing an increase of $170.5 million, or 38.7%. The components of revenue were as follows:

Premium Revenue. Total premium revenue for the first nine months of 2005 was $592.5 million as compared with $425.9 million in the comparable 2004 period, representing an increase of $166.6 million, or 39.1%. The components of premium revenue and the primary reasons for changes were as follows:

Medicare: Medicare premiums were $498.0 million in the first nine months of 2005 versus $314.4 million in the prior year, representing an increase of $183.6 million, or 58.4%. The primary factors affecting changes in Medicare premium revenue include membership (which we measure in member months), reimbursement rates and risk scores, the geographic mix of our Medicare members, and the mix of our members qualifying as dual-eligibles. The increase in Medicare premiums in 2005 is primarily attributable to the 43.1% increase in membership months to 708,162 for the first nine months of 2005 from 494,817 for the comparable period of 2004. An increase in our average PMPM premium to $703.20 for the first nine months of 2005 from $635.30 for the comparable period in 2004, or by 10.7%, also contributed to the increase in premium revenue. Approximately $8.2 million, or $11.52 PMPM, of the rate increase was attributable to retroactive risk payments received from CMS during the third quarter of 2005. Medicare premium revenue also benefited in 2005 from the increase in Texas membership as a percentage of our total Medicare membership because our Texas Medicare PMPM premiums are significantly higher than our average Medicare PMPM premiums. For the first nine months of 2005, Medicare premiums represented 84.0% of total premium revenue and 81.5% of total revenue as compared with 73.8% and 71.4%, respectively, for the comparable period of the prior year.

Commercial: Commercial premiums were $94.6 million in the first nine months of 2005 as compared with $111.5 million in the comparable period of the prior year, reflecting a decrease of $16.9 million, or 15.2%. The decline in commercial premiums is attributable to the decline in commercial membership months to 372,933 for the nine month period ended September 30, 2005 from 468,546 for the 2004 comparable period, or by 20.4%, which was partially offset by average commercial premium increases of approximately 6.6% over the same periods. For the first nine months of 2005, commercial premiums represented 16.0% of total premium revenue and 15.5% of total revenue versus 26.2% and 25.3%, respectively, for the comparable period in the prior year. Because of the company s Medicare program expansion into Mississippi and new areas in Tennessee, Texas, and Illinois, continuing Medicare member growth in existing service areas, our recent decision to exit the individual and small employer group commercial markets in Alabama, and the implementation of Medicare Part D in 2006, we expect commercial premium revenue as a percentage of total premium revenue and total revenue to continue to decline in the future.

Fee Revenue. Fee revenue was $15.5 million in the first nine months of 2005 as compared with $13.5 million in the comparable period of the prior year, representing an increase of $2.0 million, or 14.8%. The increase was primarily attributable to the addition of a new independent physician association in Tennessee in January 2005, increases in independent physician association management fees, which are calculated by reference to increased PMPM premiums on the commercial and Medicare business, and the increase in Medicare Advantage membership.

Investment Income. Investment income was $2.7 million for the first nine months of 2005 versus $0.8 million for the comparable period of the prior year, reflecting an increase of $1.9 million, or 227.0%. The increase is attributable primarily to an increase in average invested and cash balances, coupled with a higher average yield on these balances.

Table of Contents

Medical Expense

Medicare medical expense for the nine months ended September 30, 2005 increased $146.7 million, or 60.2%, to $390.3 million from $243.6 million for the same period in 2004, primarily as a result of increased membership. Commercial medical expense decreased by $13.7 million, or 14.3%, to $81.7 million for the first nine months of 2005 as compared to $95.4 million for the same period of last year, which decrease was primarily the result of the decrease in commercial membership over the same period.

For the nine months ended September 30, 2005, the Medicare MLR was 78.38% versus 77.51% for the first nine months of 2004, an increase of 87 basis points, which was primarily attributable to general medical cost inflation, higher Medicare inpatient admissions per thousand, an increase in the average cost per admission, and an increase in benefits, including implementation of a fitness program in all markets and increased drug benefits in selected markets. Our Medicare medical expense calculated on a PMPM basis was $551.15 for the nine months ended September 30, 2005, compared with $492.40 for the comparable period in 2004, reflecting an increase of 11.9%, which was primarily attributable to a higher mix of dual-eligible beneficiaries in the 2005 period. The commercial MLR was 86.45% for the first nine months of 2005 as compared with 85.58% in the first nine months of the prior year, an increase of 87 basis points, which was primarily attributable to higher inpatient utilization in the Tennessee and Alabama markets and higher physician and outpatient trends in Alabama.

Selling, General, and Administrative Expense

Selling, general, and administrative, or SG&A, expense for the nine months ended September 30, 2005 was $76.2 million (not including the $8.6 million of transaction expense described below) as compared with $49.0 million for the same period last year, an increase of $27.2 million, or 55.7%. As a percentage of revenue, SG&A expense was 12.48% for the first nine months of 2005 versus 11.12% for the prior year comparable period, an increase of 136 basis points. The increase in SG&A expense was attributable, in part, to increased personnel and other spending associated with supporting and sustaining our membership growth, including expansion into new geographic areas. During late 2004 and early 2005, we commenced expansion into selected counties surrounding Chattanooga and Memphis, Tennessee as well as into the Chicago, Illinois metropolitan area. As we expand into new service areas we incur a significant amount of expense in advance of the effective member enrollment dates, when we begin to collect revenue for new members. During the first nine months of 2005, the company incurred approximately $4.4 million of pre-enrollment expense associated with this expansion activity. In addition, in the 2005 nine month period we incurred approximately $0.9 million of incremental expense relating primarily to sales and marketing activities associated with the implementation of our Medicare Part D programs and new membership recruitment and enrollment. We expect to incur approximately $2.4 million in additional expenses during the remainder of 2005 in preparation for the January 1, 2006 Part D implementation.

Transaction Expense

Transaction expenses of $8.6 million were incurred in the first nine months of 2005 in conjunction with the recapitalization. This expense includes fees paid to financial and legal advisors and other expenses, including $1.7 million related to the proposed settlement of an agreement to issue additional consideration to RPO. Based on these discussions, we have accrued an additional $2.3 million of transaction expense during the quarter ended December 31, 2005 relating to this settlement. See Certain Relationships and Related Transactions RPO Relationships and Note 12 to the unaudited consolidated financial statements of the Company for the nine months ended September 30, 2005.

Table of Contents

Depreciation and Amortization Expense

Depreciation and amortization expense was $5.1 million in the first nine months of 2005 as compared with $2.4 million in the comparable period of the prior year, representing an increase of $2.7 million, or 112.5%, which increase was primarily attributable to the amortization of identifiable intangible assets recorded in conjunction with the recapitalization. Amortization related to the recapitalization in the amount of $3.3 million was recorded during the first nine months of 2005. Management currently expects that amortization relating to the identifiable intangible assets recorded in the recapitalization for the remainder of 2005 will be approximately $1.4 million and for the full 2006 year will be approximately $5.7 million.

Interest Expense

Interest expense was $10.2 million in the first nine months of 2005. Almost all of the company s interest expense relates to the senior credit facility and senior subordinated notes put in place in conjunction with the recapitalization. For the nine months ended September 30, 2005, we recorded interest expense of $6.4 million related to our senior credit facility and $3.2 million related to our senior subordinated notes. Additionally, interest expense in the first nine months of 2005 includes $0.6 million for amortization of deferred finance costs. The effective interest rate during the first nine months of 2005 on the senior credit facility was 6.6% per year and on the senior subordinated notes was 15% per year, 12% of which is payable in cash and 3% of which accrues quarterly and is added to the outstanding principal amount. We currently expect to use our net proceeds from the offering, together with available cash, to repay all of our outstanding indebtedness. Accordingly, we anticipate interest expense will decline substantially in subsequent periods.

Minority Interest

Minority interest was $2.5 million in the first nine months of 2005 as compared with $5.1 million in the same period last year. The change is attributable to the reduction of minority interest ownership in our Tennessee management subsidiaries and Texas HealthSpring, LLC in connection with the recapitalization. The earnings of these subsidiaries increased in 2005 as compared with 2004, which would have resulted in an increase in minority interest if it had not been offset by our increase in ownership.

Income Tax Expense

For the nine months ended September 30, 2005, income tax expense was $14.8 million, reflecting an effective tax rate of 41.0%, versus $7.1 million, reflecting an effective tax rate of 15.8%, for the comparable period in 2004. The increase in the effective tax rate is a result of the fact that our predecessor and several of its subsidiaries were pass-through tax entities that were taxed at the member level and the successor is taxed on a consolidated basis at the corporate level.

Preferred Dividend

In the nine months ended September 30, 2005, we accrued $10.8 million of dividends payable on the preferred stock issued in connection with the recapitalization. The $227.2 million liquidation value of preferred stock has an accumulating dividend of 8%, whether declared or paid. The preferred stock will automatically convert into common stock immediately prior to the consummation of this offering, based upon the liquidation value, $1,000 per share, of the preferred stock, plus accrued and unpaid dividends thereon, divided by the initial public offering price. See Certain Relationships and Related Transactions Terms of Preferred Stock.

Table of Contents

Comparison of Year Ended December 31, 2004 to Year Ended December 31, 2003

As previously noted, prior to April 1, 2003, the predecessor accounted for its Tennessee management subsidiary, HealthSpring Management, Inc., or HSMI, including HSMI s wholly owned subsidiary, HealthSpring of Tennessee, Inc., or HTI, our Tennessee HMO, using the equity method. On April 1, 2003, the predecessor increased its ownership of HSMI to 83% and consolidated the results of HSMI and HTI for the balance of 2003 and all of 2004. Although not in accordance with GAAP, management believes the changes from 2003 to 2004 in results of operations and the reasons therefor are best understood by comparing 2004 as reported to 2003 as adjusted to reflect HSMI on an as if consolidated basis for the first quarter of 2003. The adjustments to statement of income data for 2003 to reflect HSMI on an as if consolidated basis are set forth in the table below:

	Year Ended December 31, 2003 Predecessor	HSMI for the Period from January 1, 2003 through March 31, 2003	Year Ended December 31, 2003 As Adjusted	Year Ended December 31, 2004
	(In thousands)			
Revenue:				
Premium:				
Medicare premiums	$ 240,037	$ 58,794	$ 298,831	$ 433,729
Commercial premiums	120,877	20,187	141,064	146,318
Total premiums	360,914	78,981	439,895	580,047
Fee revenue	11,054	(52)	11,002	17,919
Investment income	695	136	831	1,449
Total revenue	372,663	79,065	451,728	599,415
Expenses:				
Medical expense				
Medicare expense	187,368	51,385	238,753	338,632
Commercial expense	104,164	15,772	119,936	124,743
Total medical expense	291,532	67,157	358,689	463,375
Selling, general and administrative	50,576	7,507	58,083	68,868
Phantom stock compensation				24,200
Depreciation and amortization	2,361	412	2,773	3,210
Interest	256		256	214
Total operating expenses	344,725	75,076	419,801	559,867
	27,938	3,989	31,927	39,548

Income before equity in earnings of unconsolidated affiliates, minority interest, and income taxes				
Equity in earnings of unconsolidated affiliates	2,058	(1,994)	64	234
Income before minority interest and income taxes	29,996	1,995	31,991	39,782
Minority interest	(5,519)	(1,995)	(7,514)	(6,272)
Income before income taxes	24,477		24,477	33,510
Income tax expense	5,417		5,417	9,193
Net income	$ 19,060	$	$ 19,060	$ 24,317

Table of Contents

Membership

Our Medicare Advantage membership increased by 33.2%, to 63,792 members at December 31, 2004, as compared to 47,899 members at December 31, 2003. This increase was attributable to growth in membership in all of our existing markets Tennessee (4,090, or 15.9%, increase in members), Texas (5,584, or 35.7%, increase), and Alabama (6,219, or 95.8%, increase) through increased penetration in existing service areas and geographic expansion into new counties contiguous to existing service areas. Our commercial membership declined by 10.9% over the same period, from 54,280 to 48,380, primarily as a result of the decision to discontinue certain unprofitable customer and provider relationships and markets in Alabama and Tennessee.

Revenue

Total revenue was $599.4 million for 2004 as compared with $451.7 million for 2003, as adjusted, an increase of $147.7 million, or 32.7%. The components of revenue were as follows:

Premium Revenue. Total premium revenue for 2004 was $580.0 million as compared with $439.9 million in 2003, as adjusted, representing an increase of $140.1 million, or 31.8%. Total premium revenue accounted for 96.8% and 97.4%, as adjusted, of our total revenue in 2004 and 2003, respectively. The components of premium revenue were as follows:

Medicare: Medicare premium revenue for 2004 was $433.7 million versus $298.8 million in 2003, as adjusted. The increase in Medicare premium revenue in 2004 by $134.9 million, or 45.1%, over 2003 is primarily attributable to a 13.0% increase in our average PMPM premiums, to $635.66 in 2004 from $562.53 in 2003, and a 28.4% increase in Medicare member months, to 682,331 in 2004 from 531,266 in 2003. Medicare premium revenues also increased because of the accelerating growth of Medicare members, particularly dual-eligible members, in Texas and Alabama, where our PMPM reimbursement rates were higher than in Tennessee. Medicare premium revenue accounted for 74.8% of total premium revenue in 2004 as compared to 67.9% of total premium revenue in 2003, as adjusted.

Commercial. Commercial premiums were $146.3 million in 2004 as compared with $141.1 million in 2003, as adjusted, reflecting an increase of $5.2 million, or 3.7%. The increase in commercial premiums is attributable to an average premium increase of $19.37, or 8.7%, which was partially offset by a 4.7% decline in commercial member months.

Fee Revenue. Fee revenue was $17.9 million for 2004 as compared with $11.0 million, as adjusted, in the prior year, an increase of $6.9 million, or 62.9%. The increase was primarily attributable to increased Medicare membership and Medicare premiums in our managed independent physician associations.

Investment Income. Investment income was $1.4 million for 2004 as compared with $0.8 million for the prior year, as adjusted, reflecting an increase of $0.6 million, or 74.4%. The increase is attributable primarily to an increase in average invested balances.

Medical Expense

Total medical expense for 2004 was $463.4 million as compared with $358.7 million for 2003, as adjusted, reflecting an increase of $104.7 million, or 29.2%. Medicare medical expense for 2004 was $338.6 million as compared $238.8 million for 2003, as adjusted. Commercial medical expense for 2004 was $124.7 million as compared to $119.9 million for 2003, as adjusted.

Table of Contents

The components of medical expense and the corresponding MLR, by line of business were, for the periods indicated, as follows:

	2003 As Adjusted	2004
	(In thousands)	
Premium Revenue:		
Medicare	$ 298,831	$ 433,729
Commercial	141,064	146,318
	$ 439,895	$ 580,047
Medical Expense:		
Medicare	$ 238,753	$ 338,632
Commercial	119,936	124,743
	$ 358,689	$ 463,375
Medical Loss Ratio (MLR):		
Medicare	79.90%	78.07%
Commercial	85.02%	85.25%

For 2004, the Medicare MLR was 78.07% compared with 79.90% for 2003, as adjusted, a decrease of 183 basis points. The decline in Medicare MLR in 2004 was primarily the result of the favorable impact of risk adjusted revenue received from CMS during the third quarter of 2004, which included positive retrospective adjustments back to January 2004. Our Medicare medical expense calculated on a PMPM basis was $496.29 for 2004 compared with $449.40 for 2003, as adjusted, reflecting an increase of 10.4%. Commercial MLR of 85.25% in 2004 was relatively flat as compared to 85.02% in 2003, as adjusted.

Selling, General, and Administrative Expense

SG&A expense for 2004 was $68.9 million versus $58.1 million in 2003, as adjusted, reflecting an increase of $10.8 million, or 18.6%. This increase over 2003 was primarily attributable to an increase in headcount, an increase in general advertising and marketing expense, and approximately $1.3 million of incremental administrative expense associated with the new market expansion into Illinois. As a percentage of total revenue, SG&A expense was 11.49% for 2004 versus 12.86% for 2003, as adjusted, a decrease of 137 basis points.

Phantom Stock Compensation

An expense of $24.2 million was incurred in 2004 in conjunction with the recapitalization. This amount reflects the compensation expense associated with the conversion, as of December 31, 2004, by our employees of phantom membership units in the predecessor into 306,025 membership units of the predecessor in anticipation of the recapitalization.

Depreciation and Amortization Expense

Depreciation and amortization expense for 2004 was $3.2 million as compared with $2.8 million in 2003, as adjusted, reflecting an increase of $0.4 million, or 15.76%. This increase was primarily attributable to additional depreciation on new assets purchased and increased amortization resulting from a full year of ownership of two preferred provider organization networks purchased in September 2003.

Minority Interest

Minority interest for 2004 was $6.3 million as compared with $7.5 million in 2003, as adjusted. This change was primarily attributable to the acquisition of an additional 35% interest in the Tennessee management subsidiaries during 2003.

46

Table of Contents

Income Tax Expense

Income tax expense for 2004 was $9.2 million versus $5.4 million in 2003, reflecting an increase of $3.8 million, or 70.4%. This increase over 2003 was primarily attributable to an increase in 2004 in taxable income of $9.1 million.

Comparison of Year Ended December 31, 2003 to Year Ended December 31, 2002

Membership

Our Medicare Advantage membership increased by 42.7%, to 47,899 members at December 31, 2003, as compared to 33,560 members at December 31, 2002. This increase was attributable to growth in membership in all of our existing markets Tennessee (2,794, or 12.2%, increase in members), Texas (7,919, or 102.6%, increase), and Alabama (3,626, or 126.6%, increase). We established our HMO operations in Texas in November 2002; prior to which our Texas operations had been limited to managing independent physician associations. We also acquired our Alabama operations in November 2002. Our commercial HMO membership was relatively flat, increasing by 1.3% from 53,605 members at 2002 year end to 54,280 at December 31, 2003.

Other Statement of Income Data

Except for changes in membership described above, management believes that detailed comparisons of results of operations for 2003 when compared with 2002 are not meaningful for the following reasons:

- Reported total revenue for 2003 was $372.7 million as compared to $26.1 million for 2002. A substantial contributing factor to the increase in reported 2003 revenue versus 2002 relates to the accounting for HSMI and HTI as consolidated subsidiaries for the final nine months of 2003 and on the equity method for all of 2002.

- The effect of accounting for HSMI and HTI on a consolidated basis in 2003 versus the equity method in 2002 is the primary reason for the change in each component of net income.

- Our Alabama operations, which we acquired in November 2002, accounted for $94.5 million in premium revenue in 2003 as compared to $12.8 million for 2002.

- We added our HMO operations in Texas in November 2002, which had prior to that time been limited to managing independent physician associations. The Texas HMO accounted for $105.3 million in premium revenue in 2003 as compared to $8.9 million for 2002.

Liquidity and Capital Resources

We have historically financed our operations primarily through internally generated funds. Substantially all of the cash proceeds from the $200.0 million in debt we incurred in connection with the recapitalization was paid to members of our predecessor in exchange for their membership units or to others, primarily for expenses related to the recapitalization. We generate cash primarily from premium revenue and our primary use of cash is the payment of medical and SG&A expenses. We anticipate that our current level of cash on hand, internally generated cash flows, and borrowings available under our senior secured revolving credit facility will be sufficient to fund our working capital needs and anticipated capital expenditures over the next twelve months. Following this offering we may borrow up to $15.0 million pursuant to our existing senior secured revolving credit facility, which amount may be increased by up to $25.0 million subject to certain conditions. See Indebtedness. We currently intend to enter into a new revolving credit facility following this offering.

The reported changes in cash and cash equivalents for the years ended December 31, 2002, 2003, and 2004 and the combined nine month period ended September 30, 2005, which includes

our predecessor for the period from January 1, 2005 through February 28, 2005 and the company for the period from March 1, 2005 through September 30, 2005, are summarized below:

	Year Ended December 31,			Combined Nine Months Ended September 30,
	2002	2003	2004	2005
	(In thousands)			
Net cash provided by operating activities	$ 6,569	$ 63,392	$ 24,665	$ 114,157
Net cash (used in) provided by investing activities	(6,123)	42,647	(34,615)	(282,868)
Net cash provided by (used in) financing activities	5,748	(11,750)	(23,311)	327,726
Increase (decrease) in cash and cash equivalents	$ 6,194	$ 94,289	$ (33,261)	$ 159,015

Cash Flows from Operating Activities

Our cash flows are heavily influenced by the timing of the Medicare Advantage premium remittance from CMS, which is payable to us on the first day of each month. This payment is sometimes received in the last couple of days of the month prior to the month of medical coverage. When this happens, we record the receipt in deferred revenue and recognize it as premium revenue in the month of medical coverage. The January 2004 payment in the amount of $28.6 million was received in December of 2003 which had the effect of increasing operating cash flows in that year with a corresponding decrease in the following year. Similarly, the October 2005 payment in the amount of $68.6 million was received in September 2005 and has been recorded on our balance sheet as of September 30, 2005 as deferred revenue. If you were to adjust our operating cash flows in 2003 and 2004 for the effect of the timing of this payment, our operating cash flows would have been as follows:

	Year Ended December 31,			Combined Nine Months Ended September 30,
	2002	2003	2004	2005
	(In thousands)			
Net cash provided by operating activities, as reported	$ 6,569	$ 63,392	$ 24,665	$ 114,157
Timing effect of CMS payment		(28,597)	28,597	(68,612)
Adjusted cash flow	$ 6,569	$ 34,523	$ 53,534	$ 45,545

Nine Months Ended September 30, 2005

During the combined nine months of 2005, we generated $10.5 million of net income available to common stockholders and made a net investment in working capital of $19.7 million. Net income available to common stockholders had been reduced as a result of depreciation and amortization in the amount of $5.1 million, preferred stock dividends in the amount of $10.8 million and minority interest of $2.5 million, all of which represented non-cash items.

2004 Compared With 2003

The increase in adjusted cash flow for 2004 as compared with 2003 is primarily attributable to increases in membership and premiums. For the period ended December 31, 2004, the major components of adjusted operating cash flow were net income of $24.3 million, offset by an investment in net working capital of approximately $6.1 million. Net income for the period ended December 31, 2004 had been reduced for depreciation and amortization in the amount of

$3.2 million, expense related to phantom stock compensation in the amount of $24.2 million and minority interest of $6.3 million, all of which represented non-cash items.

2003 Compared With 2002

The increase in adjusted cash flow for 2003 as compared with 2002 is primarily attributable to increases in membership and premiums, and the effect of the consolidation of acquired subsidiaries during 2003 that were not included in the company s 2002 operations. The increased operating cash flow in 2003 as compared with 2002 is primarily attributable to the company s increased net income associated with a significantly higher membership and corresponding volume related increases in the liability components of working capital, primarily claims and other accounts payable. Net income and net working capital increased by $10.4 million and $7.2 million, respectively, in 2003.

Cash Flows from Investing and Financing Activities

For the combined nine months ended September 30, 2005, the primary investing and financing activities related to the recapitalization. The company also had $2.2 million of capital expenditures. During 2004, the company made distributions to its members and minority interest holders of its subsidiary companies in the amount of $22.6 million and purchased $32.2 million of investments. Additionally, the company had capital expenditures in the amount of $2.5 million.

For the year ended December 31, 2003, the company s primary investing activity was the purchase of an additional 33% interest in HSMI for $620,000. As a result of this purchase, the company commenced consolidating this entity as a subsidiary and thus for accounting purposes was deemed to have acquired approximately $37.5 million of cash on HSMI s balance sheet. Additionally, the company had $3.2 million of capital expenditures in 2003 and made distributions to members of $10.9 million. These payments were partially financed through proceeds from the maturity of investments in the amount of $10.1 million.

Statutory Capital Requirements

Our HMO subsidiaries are required to maintain satisfactory minimum net worth requirements established by the respective state departments of insurance. At September 30, 2005, the statutory minimum net worth requirements were $12.1 million in the aggregate, which was comprised of $8.1 million for HealthSpring of Tennessee, Inc.; $1.1 million for HealthSpring of Alabama, Inc.; and $2.9 million for Texas HealthSpring, LLC. Each of these subsidiaries was in compliance with applicable statutory capital requirements as of September 30, 2005. The HMOs are restricted from making certain distributions to the company without appropriate regulatory notifications and approvals or to the extent such distributions would put them out of compliance with statutory capital requirements. At September 30, 2005, $188.4 million out of a total of $205.8 million of the company s cash, cash equivalents, investment securities, and restricted investments were held by the company s HMO subsidiaries and subject to these distribution restrictions.

Indebtedness

In connection with the recapitalization, our subsidiary, NewQuest, Inc., entered into a senior credit facility and issued senior subordinated notes. We used borrowings under the senior credit facility and proceeds from the issuance of the senior subordinated notes, net of $6.3 million of fees recorded as deferred financing costs, as well as proceeds from the issuance of the preferred and common stock, to fund the cash payments to the members of NewQuest, LLC in the recapitalization and for other related expenses and payments.

Table of Contents

The senior credit facility provides for borrowings in an aggregate principal amount of up to $180.0 million, which includes:

- A senior secured term loan facility in an aggregate principal amount of up to $165.0 million, which we refer to as the term loan facility, which had $156.8 million principal amount outstanding as of September 30, 2005; and
- A senior secured revolving credit facility in an aggregate principal amount of up to $15.0 million, none of which had been drawn as of September 30, 2005.

We intend to use our net proceeds from this offering, together with available cash, to repay and redeem all amounts outstanding under the term loan portion of the senior credit facility and the senior subordinated notes. For more information see Use of Proceeds. Following this offering, our senior secured revolving credit facility will remain in effect, under which we may borrow up to $15.0 million aggregate principal amount, which amount may be increased by up to $25.0 million, subject to certain conditions. We currently intend to enter into a new revolving credit facility following this offering.

Amounts borrowed by us under the term loan facility bore interest at floating rates, which could be either a base rate or, at our option, a LIBOR rate plus, in each case, an applicable margin. On July 1, 2005, we elected the base rate option and amounts borrowed under the term loan facility bore interest at an annual rate of 6.66% for the period through December 31, 2005. As required by our term loan facility, we entered into an interest rate swap agreement in July 2005, pursuant to which $25.0 million of the principal amount outstanding under the term loan facility will bear interest at a fixed annual rate of 4.25% plus the applicable margin (currently 3.0%) for the period from January 1, 2006 to June 30, 2006. The term loan facility matures on March 1, 2011. We must make a quarterly amortization payment on the term loan facility equal to $4.125 million through 2008 and increased amounts thereafter. The revolving credit facility matures, and commitments relating to the revolving credit facility terminate, on March 1, 2010. The obligations under the senior credit facility are guaranteed by us and all of our non-HMO subsidiaries and are secured by all of our assets.

The senior credit facility contains various financial covenants, including covenants with respect to leverage ratio, interest and fixed charge coverage ratio, and capital expenditures, as well as restrictions on undertaking specified corporate actions including, among others, asset dispositions, acquisitions, payment of dividends, changes in control, incurrence of additional indebtedness, creation of liens, and transactions with affiliates. We were in compliance with these financial and restrictive covenants as of September 30, 2005.

The senior subordinated notes, issued by our subsidiary NewQuest, Inc., bear interest at an annual rate of 15%, 12% of which is payable quarterly in cash and 3% of which accrues quarterly and is added to the outstanding principal amount. The notes mature on March 1, 2012 and are guaranteed by us and our non-HMO subsidiaries on a basis subordinated to the senior credit facility. The agreements governing the notes contain financial and restrictive covenants substantially similar to those of the senior credit facility.

Preferred Stock

We sold shares of preferred stock to the GTCR Funds, members of our predecessor, and certain other new investors in connection with the recapitalization. The holders of the preferred stock are entitled to an 8% cumulative dividend per year, which accrues on a daily basis and accumulates quarterly commencing on March 31, 2005, on the sum of the liquidation value of $1,000 per share plus all accumulated and unpaid dividends. The dividends are paid when declared by the board of directors, provided that these dividends accrue whether or not they have been declared. As of September 30, 2005, accrued but unpaid dividends totaled $10.8 million. We can redeem the shares at any time for their liquidation value of $1,000 per share plus all accrued but unpaid dividends. The preferred stock has no voting rights. Additionally, only through the affirmative vote of the holders of a

majority of the shares of preferred stock can we be required to use the net proceeds of any public offering to redeem the preferred shares for cash in an amount equal to their liquidation value, $1,000 per share, plus all accrued but unpaid dividends. If not redeemed, the preferred stock will automatically convert into common stock based on the aggregate liquidation value of the preferred stock, which includes all accrued but unpaid dividends, divided by a number which is equal to the public offering price per share of our common stock in this offering. The GTCR Funds, holders of greater than a majority of the shares of preferred stock, have advised us that they do not intend to seek a redemption of the preferred stock in connection with this offering. See Certain Relationships and Related Transactions Terms of Preferred Stock.

Off-Balance Sheet Arrangements

At September 30, 2005, we did not have any off-balance sheet arrangement requiring disclosure.

Commitments and Contingencies

Substantially all of our contractual commitments and contingencies requiring disclosure are related to the recapitalization and arose after December 31, 2004. The following table sets forth information regarding our contractual obligations as of September 30, 2005:

	Payments due by period: (In thousands)				
Contractual Obligations	**Total**	**Less than 1 year**	**1 to 3 years**	**3 to 5 years**	**More than 5 years**
Long term debt(1)	$ 205,731	$ 26,388	$ 49,455	$ 44,976	$ 84,912
Line of credit(1)	336	76	152	108	
Subordinated debt(1)	74,402	4,373	9,170	9,741	51,399
Medical claims	69,023	69,023			
Operating lease obligations(2)	16,226	4,381	6,942	4,530	373
Other contractual obligations	348	72	144	132	
Total	$ 366,066	$ 104,313	$ 65,863	$ 59,487	$ 136,402

(1) Payments on long-term debt include principal and interest. At September 30, 2005, there was $156,750 of principal on long-term debt outstanding. Principal is paid quarterly in the amount of $4,125 through 2008, and at increased amounts thereafter. The long-term credit facility bears interest at a floating rate, which is 6.66% for the period through December 31, 2005. For purposes of this table, the company has assumed that this interest rate on the long-term credit facility will remain at 6.66% for the term of the debt. The subordinated debt is non-amortizing debt that bears interest at 15%, 12% of which is paid quarterly in cash and 3% of which accrues quarterly and is added to the outstanding principal amount. The subordinated debt matures on March 1, 2012. There is no amount outstanding under the line of credit. The amount shown for the line of credit in the table is for an availability fee of 0.5% on the limit of $15,000.

(2) Includes leases for office space and equipment.

Critical Accounting Policies and Estimates

The preparation of our consolidated financial statements requires our management to make a number of estimates and assumptions relating to the reported amount of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses

during the period. We base our estimates on historical experience and on various other assumptions that we believe are reasonable under the circumstances. Changes in estimates are recorded if and when better information becomes available. Actual results could significantly differ from those estimates under different assumptions and

Table of Contents

conditions. We believe that the accounting policies discussed below are those that are most important to the presentation of our financial condition and results of operations and that require our management s most difficult, subjective, and complex judgments.

Medical Expense and Medical Claims Liability

Medical expense is recognized in the period in which services are provided and includes an estimate of the cost of medical expense that has been incurred but not yet reported, or IBNR. Medical expense includes claim payments, capitation payments, and pharmacy costs, net of rebates, as well as estimates of future payments of claims incurred. Capitation payments represent monthly contractual fees disbursed to physicians and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members prescription drug benefits, net of rebates from drug manufacturers. Rebates are recognized when earned, according to the contractual arrangements with the respective vendors. Premiums we pay to reinsurers are reported as medical expenses and related reinsurance recoveries are reported as deductions from medical expenses.

The medical claims liability includes medical claims reported to the plans as well as an actuarially determined estimate of claims that have been incurred but not yet reported to the plans.

The following table presents the components of our medical claims liability as of the dates indicated:

	December 31,		September 30,
	2003	2004	2005
	(In thousands)		
Incurred but not reported (IBNR)	$ 44,717	$ 50,432	$ 64,054
Reported claims	3,012	2,755	4,969
Total medical claims liability	$ 47,729	$ 53,187	$ 69,023

The IBNR component of total medical claims liability is based on our historical claims data, current enrollment, health service utilization statistics, and other related information. Estimating IBNR is complex and involves a significant amount of judgment. Accordingly, it represents our most critical accounting estimate. Changes in this estimate can materially affect, either favorably or unfavorably, our consolidated operating results and overall financial position.

Our policy is to record management s best estimate of medical expense incurred but not reported. Using actuarial models, we calculate a minimum amount and maximum amount of the IBNR component. To most accurately determine the best estimate, our actuaries determine the point estimate within their minimum and maximum range by similar medical expense categories within lines of business. The medical expense categories are in-patient facility, outpatient facility, all professional expense and pharmacy. The lines of business are Medicare and commercial. At each of December 31, 2003 and 2004 and September 30, 2005, our point estimate was at or near the maximum amount of our IBNR range. The development of the IBNR estimate generally considers favorable and unfavorable prior period developments and uses standard actuarial developmental methodologies, including completion factors, claims trends, and provisions for adverse claims developments.

The completion factor method estimates liabilities for claims based upon the historical lag between the month when services are rendered and the month claims are paid and takes into consideration factors such as expected medical cost inflation, seasonality patterns, product mix, and membership changes. The completion factor is a measure of how complete the claims paid to date are relative to the estimate of the total claims for services rendered for a given reporting period. Although the completion factor is generally reliable for older service periods, it is more volatile, and hence less reliable, for more recent periods given

that the typical billing lag for services can range from a week to as much as 90 days from the date of service. As a result, for the most recent two to

Table of Contents

four months, the estimate for incurred claims is developed from a trend factor analysis based on per member per month claims trends experienced in the preceding months. We apply different estimation methods depending on the month of service for which incurred claims are being estimated. For the more recent months, which constitute the majority of the amount of IBNR, we estimate our claims incurred by applying the observed trend factors to the PMPM. For prior months, costs have been estimated using completion factors. In order to estimate the PMPMs for the most recent months, we validate our estimates of the most recent months utilization levels to the utilization levels in older months using actuarial techniques that incorporate a historical analysis of claim payments, including trends in cost of care provided, and timeliness of submission and processing of claims.

Our use of the claims trend factor method considers many aspects of the managed care business that are not predictable with consistency. These considerations are aggregated in the medical expense trend and include the incidences of illness or disease state (such as cardiac heart failure cases, cases of upper respiratory illness, the length and severity of the flu season, diabetes, and the number of neonatal intensive care babies). Accordingly, we rely upon our historical experience, as continually monitored, to reflect the ever-changing mix, needs and growth of our members in our trend assumptions. Among the factors considered by management are changes in the level of benefits provided to members, seasonal variations in utilization, identified industry trends, and changes in provider reimbursement arrangements, including changes in the percentage of reimbursements made on a capitated as opposed to a fee-for-service basis. Other external factors such as government-mandated benefits or other regulatory changes, catastrophes, and epidemics may impact medical expense trends. Other internal factors, such as system conversions and claims processing interruptions may impact our ability to accurately predict estimates of historical completion factors or medical expense trends. Medical expense trends potentially are more volatile than other segments of the economy.

Our provision for adverse claims development is intended to account for variability in the following types of factors:

- changes in claims payment patterns to the extent to which emerging claims payment patterns differ from the historical payment patterns selected to calculate the IBNR reserve estimate;
- differences between the estimated PMPM incurred expense for the most recent months and the expected PMPM based on historical PMPM incurred estimates and the estimated trend from the historical period to the most recent months;
- differences between the estimated impact of known differences in environmental factors and the actual impact of known environmental factors; and
- the healthcare expense impact of present but unknown environmental factors that differ from historical norms.

We believe that our provision for adverse claims development is appropriate because hindsight has often shown that at least a portion of this reserve has been used to cover additional claims not covered by the standard model IBNR estimate and that were incurred prior to but paid after period end. For the years ended December 31, 2003 and 2004, our provision for adverse claims development has been relatively consistent, varying as of the end of each annual period ended December 31 by less than 1.0% of medical claims liability. Fluctuations within those periods and as of the period ends are primarily attributable to differences in membership mix between Medicare and commercial plans and differences in services (such as in-patient or outpatient services) provided by our plans. Based on these fluctuations, we expect that our experience on a going-forward basis would result in our provision for adverse claims, as a percentage of medical claims liability, not varying by more than 1.0% from one quarterly period to the next. For purposes of measuring sensitivity, a 1.0% difference between our December 31, 2004 estimated claims liability and the

Table of Contents

ultimate claims paid would increase or decrease net income for the year ended December 31, 2004 by approximately $530,000.

The completion and claims trend factors are the most significant factors impacting the IBNR estimate. The following table illustrates the sensitivity of these factors and the impact on our operating results caused by changes in these factors that management believes are reasonably likely based on our historical experience and December 31, 2004 data, our most recent full fiscal year:

Completion Factor(a)		Claims Trend Factor(b)	
Increase (Decrease) in Factor	Increase (Decrease) in Medical Claims Liability	Increase (Decrease) in Factor	Increase (Decrease) in Medical Claims Liability
	(Dollars in thousands)		
3%	$ (1,542)	(3)%	$ (1,606)
2	(1,038)	(2)	(1,071)
1	(532)	(1)	(536)
(1)	539	1	536

(a) Impact due to change in completion factor for the most recent three months. Completion factors indicate how complete claims paid to date are in relation to estimates for a given reporting period. Accordingly, an increase in completion factor results in a decrease in the remaining estimated liability for medical claims.

(b) Impact due to change in annualized medical cost trends used to estimate PMPM costs for the most recent three months.

Each month, we re-examine the previously established medical claims liability estimates based on actual claim submissions and other relevant changes in facts and circumstances. As the liability estimates recorded in prior periods become more exact, we increase or decrease the amount of the estimates, and include the changes in medical expenses in the period in which the change is identified. In every annual reporting period, our operating results include the effects of more completely developed medical claims liability estimates associated with prior years.

The following table provides a reconciliation of changes in medical claims liability for the two year period ended December 31, 2004:

	2003	2004
	(In thousands)	
Balance at January 1	$ 7,661	$ 47,729
Consolidation of HSMI	32,367	
Incurred related to:		
Current year	295,864	467,289
Prior year	(4,332)	(3,914)
Total incurred	291,532	463,375
Paid related to:		
Current year	253,682	415,136

Prior year	30,149	42,781
Total paid	283,831	457,917
Balance at December 31	$ 47,729	$ 53,187

Negative amounts reported for incurred related to prior years result from claims being ultimately settled for amounts less than originally estimated (a favorable development). Positive amounts reported for incurred related to prior years result from claims ultimately being settled for amounts greater than originally estimated (an unfavorable development).

As summarized in the above table, our prior period liability development has been favorable for the two year period ended December 31, 2004. During 2003, claim liability balances at

Table of Contents

December 31, 2002 ultimately settled for $4.3 million less than the amounts originally estimated. During 2004, claim liability balances at December 31, 2003 ultimately settled for $3.9 million less than the amount originally estimated. The favorable development in 2003 and 2004 was primarily attributable to differences between assumed and actual utilization and severity of claims, which are components of our claims trend factor and completion factor. For the two year period ended December 31, 2004, actual claims expense has developed favorably by 1.5% to 2.0% as compared to estimated claims expense. The favorable development in estimated prior period claims is primarily attributable to recontracting with providers, and better case management and disease management programs.

Our medical claims liability also considers premium deficiency situations and evaluates the necessity for additional related liabilities. Premium deficiency accruals were not material in relation to our medical claims liability as of December 31, 2003 or 2004.

Premium Revenue Recognition

We generate revenues primarily from premiums we receive from CMS and, to a lesser extent our commercial customers, to provide healthcare benefits to our members. We receive premium payments on a PMPM basis from CMS to provide healthcare benefits to our Medicare Advantage members, which premium is fixed on an annual basis by contract with CMS. Although the amounts we receive from CMS for each member is fixed, the amount varies among Medicare Advantage plans according to, among other things, demographics, geographic location, age, and gender. We generally receive premiums on a monthly basis in advance of providing services. Premiums collected in advance are deferred and reported as deferred revenue. We recognize premium revenue during the period in which we are obligated to provide services to our members. Any amounts that have not been received are recorded on the balance sheet as accounts receivable.

We experience adjustments to our revenue based on member retroactivity, which reflect changes in the number and eligibility status of enrollees subsequent to when revenue is billed. We estimate the amount of outstanding retroactivity each period and adjust premium revenue accordingly. The estimates of retroactivity adjustments are based on historical trends, premiums billed, the volume of member and contract renewal activity, and other information. We refine our estimates and methodologies based upon actual retroactivity experienced. To date, member-based retroactivity adjustments have not been significant.

Additionally, our Medicare premium revenue is adjusted periodically to give effect to a risk component. In the Balanced Budget Act of 1997, Congress created a rate-setting methodology that included a provision requiring CMS to implement a risk adjustment payment system for Medicare health plans. Risk adjustment uses health status indicators to improve the accuracy of payments and establish incentives for plans to enroll and treat less healthy Medicare beneficiaries. CMS initially phased in this payment methodology in 2003 whereby the risk adjusted payment represented 10% of the payment to Medicare health plans, with the remaining 90% being based on demographic factors. In 2004 and 2005, the portion of risk adjusted payments was increased to 30% and 50%, respectively, and will increase to 75% in 2006 and 100% in 2007. Under risk adjustment methodology, managed care plans must capture, collect, and submit diagnosis code information to CMS twice a year. After reviewing the respective submissions, CMS adjusts the payments to Medicare Advantage plans generally at the beginning of the calendar year and during the third quarter and then issues a final payment in a subsequent year. The third quarter payment includes a retroactivity component for the first two quarters of the year. We do not attempt to estimate the impact of these risk adjustments and as such record them on an as-received basis. As a result, our CMS PMPM premiums may change materially, either favorably or unfavorably. Our retroactivity adjustments in 2003, 2004, and 2005 were all positive. Although we have placed a great deal of emphasis on managing and controlling the elements that impact the risk payments, there can be no assurance that these positive trends will continue in the future.

Table of Contents

Goodwill and Other Intangible Assets

Goodwill represents the excess of costs over fair value of assets of businesses acquired. Substantially all of our goodwill and other intangible assets was recorded in connection with the recapitalization. Our primary identifiable intangible assets include our Medicare member network, our HealthSpring trade name, our provider networks, customer relationships and non-compete agreements. Goodwill is determined to have an indefinite useful life and is not amortized, but instead is tested for impairment at least annually. The Company has determined that December 31 will be its annual testing date. Poor operating results or changes in market conditions could result in an impairment of goodwill. Other intangible assets are amortized over their respective estimated useful lives to their estimated residual values and reviewed for impairment at least annually. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to future undiscounted cash flows expected to be generated by the asset. If the carrying amount of an asset exceeds its estimated future cash flows, an impairment charge is recognized by the amount by which the carrying amount of the asset exceeds the fair value of the asset.

Recent Accounting Pronouncements

In December 2004, the FASB revised SFAS No. 123, Accounting for Stock-Based Compensation, which established the fair-value-based method of accounting as preferable for share-based compensation awarded to employees and encouraged, but did not require, entities to adopt it until July 1, 2005. On April 14, 2005, the Securities and Exchange Commission announced that it would provide for a phased-in implementation process that allowed non-small business registrants with a fiscal year ended December 31, 2005 an extension until January 31, 2006 to adopt SFAS No. 123(R), Share-Based Payment. SFAS No. 123(R) eliminates the alternative to use APB Opinion No. 25, Accounting for Stock Issued to Employees, which allowed entities to account for share-based compensation arrangements with employees according to the intrinsic value method. SFAS No. 123(R) requires the measurement of the cost of employee services received in exchange for an award of equity instruments based on the grant-date fair value of the award. The cost will be recognized over the period during which an employee is required to provide service in exchange for the award. No compensation cost is recognized for equity instruments for which employees do not render service. The Company plans to adopt SFAS No. 123(R) on January 1, 2006, requiring compensation cost to be recorded as expense for the portion of outstanding unvested awards, based on the grant-date fair value of those awards. We are currently evaluating the effect the adoption of SFAS No. 123(R) will have on our financial position and results of operation.

In May 2005, the FASB issued SFAS No. 154, Accounting Changes and Error Corrections A Replacement of APB Opinion No. 20, Accounting Changes (APB 20), and FASB Statement No. 3, Reporting Accounting Changes in Interim Financial Statements (SFAS No. 154). APB 20 previously required that most voluntary changes in accounting principles be recognized by including in net income of the period of the change the cumulative effect of changing to the new accounting principle. SFAS No. 154 requires retrospective application to prior periods financial statements of changes in accounting principles, unless it is impracticable to determine either the period-specific effects or the cumulative effect of the change. SFAS No. 154 also requires that retrospective application of a change in accounting principle be limited to the direct effects of the change. Indirect effects of a change in an accounting principle, such as a change in nondiscretionary profit-sharing payments resulting from an accounting change, should be recognized in the period of the accounting change. SFAS No. 154 also requires that a change in depreciation, amortization, or depletion method for long-lived, nonfinancial assets be accounted for as a change in accounting estimate effected by a change in accounting principle. SFAS No. 154 is effective for accounting changes and corrections of errors made in fiscal years beginning after December 15, 2005. We will adopt the provisions of SFAS No. 154 effective January 1, 2006. The impact of SFAS No. 154 will depend on the accounting change, if any, in a future period.

Table of Contents

Qualitative and Quantitative Disclosures about Market Risk

As of December 31, 2004 and September 30, 2005, we had the following assets that may be sensitive to changes in interest rates:

Asset Class	December 31, 2004	September 30, 2005
	(In thousands)	
Investment securities, available for sale	$ 8,460	$ 8,806
Investment securities, held to maturity:		
Current portion	9,413	5,670
Long-term portion	20,248	35,290
Restricted investments	5,319	5,667

We have not purchased any of our investments for trading purposes. Our investment securities classified as available for sale are repurchase agreements. For all other investment securities we intend to hold them to their maturity and classify them as current on our balance sheet if they mature between three and 12 months from the balance sheet date and as long-term if their maturity is more than one year from the balance sheet date. These investment securities, both current and long-term, consist of highly liquid government and corporate debt obligations, a substantial majority of which mature in five years or less. The investments classified as long-term are subject to interest rate risk and will decrease in value if market rates increase. Because of their relatively short-term nature, however, we would not expect the value of these investments to decline significantly as a result of a sudden change in market interest rates. Moreover, because of our ability and intent to hold these investments until maturity (or at least until a market price recovery), we would not expect foreseeable changes in interest rates to materially impair their value. Restricted investments consist of certificates of deposit and government securities deposited or pledged to state departments of insurance in accordance with state rules and regulations. At December 31, 2004 and September 30, 2005, these restricted assets are recorded at amortized cost and classified as long-term regardless of the contractual maturity date because of the restrictive nature of the states requirements.

Assuming a hypothetical and immediate 1% increase in market interest rates at September 30, 2005, the fair value of our fixed income investments would decrease by less than $400,000. Similarly, a 1% decrease in market interest rates at September 30, 2005 would result in an increase of the fair value of our investments by less than $400,000. Unless we determined, however, that the increase in interest rates caused more than a temporary impairment in our investments, or unless we were compelled by a currently unforeseen reason to sell securities, such a change should not affect our future earnings or cash flows.

As of September 30, 2005, we had approximately $156.8 million principal amount of variable rate debt outstanding under our senior credit facility. Interest rate changes do not affect the market value of such debt but do impact the amount of our interest payments and, accordingly, our future earnings and cash flows, assuming other factors are held constant. An immediate 1% increase in market interest rates used to calculate our interest at September 30, 2005 would result in an increase in annual interest expense of approximately $1.6 million.

As required by our term loan facility, we entered into an interest rate swap agreement in July 2005, pursuant to which $25.0 million of the principal amount outstanding under the term loan facility will bear interest at a fixed annual rate of 4.25% plus the applicable margin (currently 3.00%) for the period from January 1, 2006 to June 30, 2006. The swap does not qualify for hedge accounting. Accordingly, the company will record the change in the swap s fair market value as a component of earnings. At September 30, 2005, the fair market value of the swap was $29,000.

Table of Contents

BUSINESS

Overview

We believe we are one of the largest managed care organizations in the United States whose primary focus is the Medicare Advantage market. Our belief is based upon membership data as published by the Centers for Medicare and Medicaid Services, or CMS, and upon published reports by Wall Street advisory firms covering managed care companies that derive at least a majority of their total revenue from the Medicare Advantage market. 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 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 MMA, the Congressional Budget Office expects Medicare expenditures, without taking into account the new Part D 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. We believe that the rise in 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.

Based on quarterly membership data published by CMS, we believe we have a leading Medicare market position in most of our established service areas. Moreover, based on our growth in Medicare Advantage membership relative to our competitors, we believe we have operating efficiencies, provider relationships, and brand name recognition that provide us advantages relative to our existing and potential competitors. We have historically operated in areas where there have been few or no competing Medicare Advantage plans. Although Medicare Advantage penetration varies widely nationally 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, providing significant opportunities for continued membership growth within our existing service areas. 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.

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 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 managed care populations. We believe our analytical, data-driven approach to our operations further enhances our medical expense management capabilities. We also 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 in 2006.

We commenced operations in September 2000 when our predecessor purchased an interest in an unprofitable HMO operating in the Nashville, Tennessee area. We restored that HMO to

Table of Contents

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.

The Medicare Program and Medicare Advantage

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 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. Nationwide Medicare Advantage penetration, expressed as a percentage of Medicare eligible beneficiaries who belong to a Medicare Advantage plan, is expected to increase from 13% of all Medicare enrollees in 2005 to almost 30% in 2013. Moreover, the recent decline in employer-sponsored retiree health benefits is anticipated to increase the number of persons who enroll in a Medicare Advantage plan.

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, $78.20 in 2005, 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 $125 deductible. To fill the gaps in traditional fee-for-service Medicare coverage, individuals often 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 well 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 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 benefi-

Table of Contents

ciaries including, in some Medicare Advantage plans including ours, 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.

The table below compares traditional Medicare fee-for-service premiums and benefits with those of a typical Medicare Advantage plan.

Fee-for-Service	Medicare Advantage
Monthly premium between approximately $80 to $300 for supplemental Medigap insurance	Members often pay no premium and do not require supplemental insurance
Most members are enrolled in Medicare Part B	Must be enrolled in Medicare Part B
Medicare Part D drug benefit, subject to deductibles, co-payments and coverage limits	Medicare Advantage MA-PD plans, offering varied choices for deductibles and co-payments
No coverage for certain preventive services including annual physicals or well visits, eyeglasses, hearing aids, dentures, and most dental work	Medicare Advantage plans provide benefits not available in Medicare fee-for-service
Members have to pay some money for Medicare- covered services including deductibles upon entering the hospital (Medicare Part A) and co-payments	Members will pay lower deductibles and co-payments than they would with Medicare fee-for- service
Medicare fee-for-service covers only episodic care when the beneficiary is ill	Medicare Advantage plans emphasize preventive care and provide coverage for mammograms, check-ups, and screenings for additional health problems, including diabetes and hypertension, in addition to covering episodic care when the beneficiary is ill
Members may go to any provider who accepts Medicare	Members must go to in-network providers, except for emergency services
Providers are paid from a set reimbursement schedule	Plans receive a monthly premium per member from the federal government subject to various adjustments

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+Choice 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, or BBA. This payment system was further modified pursuant to the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, or BIPA. 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

Table of Contents

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.

Largely as a result of limitations on reimbursement contained in the BBA, in many geographic areas Medicare managed care plans reduced benefits, making them less competitive with traditional fee-for-service Medicare, or withdrew from certain markets. Consequently, enrollment in Medicare managed care plans fell from approximately 6.5 million members, or 16% of eligible Medicare beneficiaries, in 2000 to approximately 4.9 million members, or 11% of eligible Medicare beneficiaries, in 2002. During this time, Medicare managed care reimbursement rates increased at an annual rate of approximately 2%, while medical costs increased at a substantially higher annual rate.

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, expanded Medicare beneficiary healthcare options by, among other things, creating a transitional temporary prescription drug discount card program for 2004 and 2005, and added 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. Effective January 1, 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, including the Part D prescription drug benefit, we expect enrollment in Medicare s managed care programs to increase in the coming years.

Prescription Drug Benefit. As part of the MMA, 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 dual-eligible beneficiaries. 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, as described below. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for member demographics and risk factor payments. The subsidy for Part D benefits is currently estimated to be $92.30 per beneficiary per month on average. The beneficiary will be 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), which is expected to result in an average premium of $32.20 per beneficiary per month, 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

61

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, will automatically be disenrolled from the Medicare Advantage plan altogether, thereby resuming traditional fee-for-service Medicare. In addition, certain dual-eligible beneficiaries will be automatically enrolled with approved PDPs in their region, as described below. Under the standard Part D drug coverage for 2006, beneficiaries enrolled in a stand-alone PDP will 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 catastrophic 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. Each Medicare Advantage plan will be required to offer a Part D drug prescription plan as part of its benefits. We currently offer prescription drug benefits through our Medicare Advantage plans and have received governmental approval to offer MA-PD benefits and stand-alone PDPs in each of our markets.

The Henry J. Kaiser Family Foundation estimates that in 2006 approximately 67% of Medicare beneficiaries will enroll in the new prescription drug benefit through a Medicare Advantage plan or a stand-alone PDP. It is currently projected that the new prescription drug benefit will account for up to 20% of Medicare spending by 2010. Furthermore, 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.

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-eligible beneficiaries receive a higher premium from CMS for dual-eligible members. Currently, CMS pays an additional premium, generally ranging from 30% to 45% more per member per month, for a dually-eligible beneficiary. This additional premium is 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