HealthSpring, Inc.
Form S-1
September 15, 2006

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As filed with the Securities and Exchange Commission on September 15, 2006
Registration No. 333-

SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form S-1
REGISTRATION STATEMENT
UNDER
THE SECURITIES ACT OF 1933
HealthSpring, Inc.
(Exact name of registrant as specified in its charter)

Delaware	**6324**	**20-1821898**
(State or other jurisdiction of incorporation or organization)	*(Primary Standard Industrial Classification Code Number)*	*(I.R.S. Employer Identification No.)*

44 Vantage Way, Suite 300
Nashville, TN 37228
(615) 291-7000
(Address, including zip code, and telephone number, including area code, of registrant s principal executive offices)

Kevin M. McNamara
Executive Vice President and Chief Financial Officer
HealthSpring, Inc.
44 Vantage Way, Suite 300
Nashville, TN 37228
(615) 291-7000
(Name, address, including zip code, and telephone number, including area code, of agent for service)

Copies to:

Howard H. Lamar III, Esq. **J. James Jenkins, Jr., Esq.** **Bass, Berry & Sims PLC** **315 Deaderick Street, Suite 2700** **Nashville, TN 37238**	**J. Gentry Barden, Esq.** **Senior Vice President and Corporate General Counsel** **HealthSpring, Inc.**	**Paul T. Schnell, Esq.** **Richard B. Aftanas, Esq.** **Skadden, Arps, Slate, Meagher & Flom LLP** **Four Times Square**

(615) 742-6200	**44 Vantage Way, Suite 300 Nashville, TN 37228 (615) 291-7000**	**New York, NY 10036 (212) 735-3000**

Approximate date of commencement of proposed sale to the public: As soon as practicable after the effective date of this Registration Statement.

If any of the securities being registered on this form are to be offered on a delayed or continuous basis pursuant to Rule 415 under the Securities Act of 1933, check the following box. o

If this Form is filed to register additional securities for an offering pursuant to Rule 462(b) under the Securities Act, please check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. o

If this Form is a post-effective amendment filed pursuant to Rule 462(c) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. o

If this Form is a post-effective amendment filed pursuant to Rule 462(d) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. o

CALCULATION OF REGISTRATION FEE

Title of Each Class of Securities to be Registered	**Amount to be Registered(1)**	**Proposed Maximum Offering Price Per Share(2)**	**Proposed Maximum Aggregate Offering Price(2)**	**Amount of Registration Fee(2)**
Common stock, par value $.01 per share	10,350,000	$20.01	$207,103,500	$22,161

(1) Includes 1,350,000 shares that may be purchased by the underwriters from certain of the selling stockholders upon exercise of the underwriters over-allotment option.

(2) Pursuant to Rule 457(c) under the Securities Act, the offering price and registration fee are based on the average of the high and low sale prices for the common stock on September 11, 2006, as reported by the New York Stock Exchange.

The Registrant hereby amends this Registration Statement on such date or dates as may be necessary to delay its effective date until the Registrant shall file a further amendment which specifically states that this Registration Statement shall thereafter become effective in accordance with Section 8(a) of the Securities Act of 1933 or until the Registration Statement shall become effective on such date as the SEC, acting pursuant to Section 8(a), may determine.

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The information in this preliminary prospectus is not complete and may be changed. These securities may not be sold until the registration statement filed with the Securities and Exchange Commission is effective. This preliminary prospectus is not an offer to sell nor does it seek an offer to buy these securities in any jurisdiction where the offer or sale is not permitted.

Subject to Completion. Dated September 15, 2006.

9,000,000 Shares

Common Stock

All of the shares of common stock in this offering are being sold by the selling stockholders identified in this prospectus. HealthSpring, Inc. will not receive any of the proceeds from the sale of the shares being sold by the selling stockholders.

The common stock is listed on the New York Stock Exchange under the symbol HS. The last reported sale price of the common stock on September 14, 2006 was $22.20 per share.

See Risk Factors beginning on page 9 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
Public offering price	$	$
Underwriting discount	$	$
Proceeds, before expenses, to the selling stockholders	$	$

To the extent that the underwriters sell more than 9,000,000 shares of common stock, the underwriters have the option to purchase up to an additional 1,350,000 shares from certain of the selling stockholders at the public offering price less the underwriting discount.

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

Joint Bookrunning Managers

Goldman, Sachs & Co.	**Citigroup**	**UBS Investment Bank**
Lehman Brothers	**Banc of America Securities LLC**	**CIBC World Markets**
Raymond James		**Avondale Partners**

Prospectus dated , 2006.

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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 this offering. The terms HealthSpring, company, we, us and o as used in this prospectus refer to HealthSpring, Inc. for periods after March 1, 2005 and to our predecessor, NewQuest, LLC, for periods prior to 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 Medicare, the federal government-sponsored health insurance program for retired U.S. citizens aged 65 and older, qualifying disabled persons, and persons suffering from end-stage renal disease. Pursuant to the Medicare Advantage program (formerly known as Medicare+Choice) and the new Medicare Part D program, Medicare beneficiaries receive healthcare benefits, including prescription drugs, through a managed care health plan. Our concentration on Medicare, and the Medicare Advantage program in particular, provides us with opportunities to understand the complexities of the Medicare program, design competitive products, manage medical costs, and offer high quality healthcare benefits to Medicare beneficiaries in our local service areas. Our Medicare Advantage 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.

On January 1, 2006, we began offering prescription drug benefits in accordance with Medicare Part D to our Medicare Advantage plan members, in addition to continuing to provide other medical benefits. We also began offering prescription drug benefits on a stand-alone basis in accordance with Medicare Part D in each of our service areas. We have filed an application with the Centers for Medicare and Medicaid Services, or CMS, to expand our stand-alone PDP program on a national basis in 2007. We sometimes refer to our Medicare Advantage plans after January 1, 2006 collectively as Medicare Advantage plans and separately as MA-only for plans without prescription drug benefits and as MA-PD for plans with prescription drug benefits. We refer to our stand-alone prescription drug plans as stand-alone PDPs or PDPs. As of January 1, 2006, we began presenting our membership by distinguishing between members of our Medicare Advantage and PDP plans. As of June 30, 2006, we had over 88,100 beneficiaries enrolled in our stand-alone PDPs.

Currently, we operate Medicare Advantage plans and offer prescription drug benefits to Medicare beneficiaries on a stand-alone basis 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. For the six months ended June 30, 2006 and the combined twelve-month period ended December 31, 2005, Medicare premiums accounted for approximately 87.2% and 82.4%, respectively, of our total revenue. As of June 30, 2006, our Medicare Advantage plans had over 107,600 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 will rise at a compounded annual growth rate of 9.3% over 10 years, from approximately $333 billion in 2005 to approximately $808 billion in 2015. 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.

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Medicare Advantage penetration, as a percentage of all 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.

We commenced our Medicare Advantage plan 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 Advantage members in five Tennessee counties in late 2000 to serving over 107,600 Medicare Advantage members in five states as of June 30, 2006. We have grown our Medicare Advantage 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 Medicare Advantage members.

The Medicare Program and Medicare Advantage

General. Medicare is funded by the federal government and administered by CMS. The Medicare eligible population is large and growing and, according to the Henry J. Kaiser Family Foundation, is approximately 43 million in 2006, and is estimated to be 46 million by 2010, 61 million by 2020, and 78 million by 2030.

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, was 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.

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 MA-PD drug benefit, while fee-for-service beneficiaries are able to purchase a stand-alone 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 were not enrolled in a Medicare Advantage plan or a stand-alone PDP at January 1, 2006 were automatically enrolled by CMS with approved PDPs in their region. The cost of the Medicare Part D prescription drug benefit is largely subsidized by the federal government.

Our Competitive Advantages

We believe the following are our key competitive advantages:

Focus on Medicare Advantage Market. We are focused primarily on the Medicare Advantage market. We believe our focus on designing and operating Medicare Advantage health plans tailored to each of our local service areas enables us to offer superior Medicare Advantage plans and to operate those plans with what we believe to be lower medical loss ratios, or MLRs. Most of our competitors offer Medicare Advantage plans that are ancillary to significantly larger commercial plans or Medicaid managed care plans.

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 Medicare Advantage members. Medicare Advantage penetration varies widely across the country because of various factors, including infrastructure and provider accessibility. We focus our efforts primarily on service areas we believe are underpenetrated by other Medicare Advantage plans, providing opportunities for us to increase the membership of our plans.

Effective Medical Management. Our medical management efforts are designed primarily for the Medicare Advantage program. For both the six months ended June 30, 2006 and the combined twelve-month period ended December 31, 2005, our Medicare MLR, excluding our PDP plans, 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;

expand our stand-alone PDP coverage on a national basis; 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 9 of this prospectus reflect risks and uncertainties

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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;
- the impact of the CMS risk adjustment payment system and budget neutrality factors;
- regulatory requirements or new legislation that could impair our operations and profitability;
- termination or nonrenewal of our Medicare contracts;
- failure to effectively manage our medical costs;
- disruption in our provider networks;
- competition from other health plan providers and failure to effectively manage and grow our plan memberships; and
- failure to properly maintain and develop effective and secure management information systems.

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

Recent Development

As previously announced, we entered into an agreement on May 30, 2006 to acquire all of the outstanding capital stock of America s Health Choice Medical Plans, Inc., or America s Health Choice or AHC, a Florida-licensed HMO currently operating Medicare Advantage health plans in the following seven Florida counties: Brevard, Broward, Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie. An affiliate of AHC operates 33 medical clinics in and around the same seven county area, which provide medical services to AHC members. We also have an option to purchase the medical clinics in the event of the closing of the AHC acquisition. In connection with the agreement, a subsidiary of HealthSpring entered into a separate agreement to manage the operations of AHC prior to closing the acquisition. For the three months ended June 30, 2006, we recognized $0.9 million of fee revenue relating to this management agreement. For the year ended December 31, 2005, America s Health Choice reported approximately $150.0 million in revenue and, as of June 30, 2006, had approximately 13,000 enrolled Medicare Advantage members and approximately 800 members in its stand-alone prescription drug plan.

Pursuant to the terms of the purchase agreement, we would pay the stockholders of America s Health Choice $50.0 million in cash, subject to an escrow for balance sheet adjustments and post-closing indemnification obligations, if any. The closing of the acquisition is subject to a number of usual and customary conditions, including the approval of CMS and Florida insurance regulators and, as described in more detail below, our satisfactory completion of due diligence relating to the operations of AHC and its affiliates.

In connection with our due diligence review of AHC and its affiliates, we have recently identified certain areas of concern relating to AHC and its affiliates, including the medical clinics. We have made AHC aware of these concerns. Our and AHC s review of these issues is in the preliminary stages and there is no definitive timetable for resolving these issues. The acquisition agreement currently provides a general right of termination by either party if its conditions to closing have not been satisfied by October 31, 2006 and by either party if closing has not occurred by December 31, 2006. We previously anticipated that the acquisition would close near the end of the third quarter or the beginning of the fourth quarter of 2006. Because of these recent developments, however, no assurance can be given

that our acquisition of AHC will be completed at all or, if it is completed, when the acquisition would close or whether the acquisition will be on the terms currently contemplated. See Risk Factors Risks Related to Our Business Our Acquisition of AHC is Subject to

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Regulatory Approval and Additional Due Diligence and May Not be Consummated on the Terms Agreed or At All.

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. 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. We completed our initial public offering, or IPO, in February 2006.

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.

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The Offering

Common stock offered by the selling stockholders	9,000,000 shares
Option to purchase additional shares granted by certain of the selling stockholders	1,350,000 shares
Common stock to be outstanding after this offering	57,236,883 shares
Use of proceeds	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 the common stock to be outstanding after this offering excludes:

- 3,054,750 shares of common stock issuable upon exercise of options issued under our equity incentive plans, at a weighted average exercise price of $18.34 per share, 25,875 of which options are currently exercisable as of September 14, 2006; and

- 3,371,500 shares of common stock reserved for future issuance under our 2006 equity incentive plan.

Except as otherwise noted, all information in this prospectus assumes the underwriters option to purchase an additional 1,350,000 shares of common stock has not been exercised.

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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.			Predecessor	HealthSpring, Inc.	
	Year Ended December 31,		Period from January 1, 2005 to February 28,	Period from March 1, 2005 to December 31,	Combined Twelve Months Ended December 31,	Period from January 1, 2005 to February 28,	Period from March 1, 2005 to June 30,	Comb Six Mon End June
	2003(1)	2004(2)	2005(3)	2005(3)	2005(4)	2005(3)	2005(3)	2005
	(Dollars in thousands, except share and unit data)							
Data:								
	$ 240,037	$ 433,729	$ 94,764	$ 610,913	$ 705,677	$ 94,764	$ 208,582	$ 303
	120,877	146,318	20,704	106,168	126,872	20,704	41,707	62
	360,914	580,047	115,468	717,081	832,549	115,468	250,289	365
	11,054	17,919	3,461	16,955	20,416	3,461	6,862	10
	695	1,449	461	3,337	3,798	461	1,039	1
	372,663	599,415	119,390	737,373	856,763	119,390	258,190	377
	187,368	338,632	74,531	478,553	553,084	74,531	166,407	240
	104,164	124,743	16,312	90,783	107,095	16,312	35,579	51
	291,532	463,375	90,843	569,336	660,179	90,843	201,986	292
	50,576	68,868	14,667	97,187	111,854	14,667	31,368	46
			6,941	4,000	10,941	6,941		6
sation		24,200						
zation	2,361	3,210	315	6,990	7,305	315	2,575	2
	256	214	42	14,469	14,511	42	5,774	5
s	344,725	559,867	112,808	691,982	804,790	112,808	241,703	354
s	2,058	234		282	282			
es	29,996	39,782	6,582	45,673	52,255	6,582	16,487	23
	(5,519)	(6,272)	(1,248)	(1,979)	(3,227)	(1,248)	(424)	(1

axes	24,477	33,510	5,334	43,694	49,028	5,334	16,063	21
	5,417	9,193	2,628	17,144	19,772	2,628	6,316	8
	19,060	24,317	2,706	26,550	29,256	2,706	9,747	12
				15,607	15,607		6,057	6
	$ 19,060	$ 24,317	$ 2,706	$ 10,943	$ 13,649	$ 2,706	$ 3,690	$ 6
basic	$ 4.67	$ 5.31	$ 0.55			$ 0.55		
diluted	4,078,176	4,578,176	4,884,196			4,884,196		
n share								
				$ 0.34			$ 0.12	
				$ 0.34			$ 0.12	
ding:								
				32,173,707			32,069,542	
				32,215,288			32,069,542	
	$ 3,198	$ 2,512	$ 149	$ 2,653	$ 2,802	$ 149	$ 1,221	$ 1
in):								
	63,392	24,665	14,964	57,139	72,103	14,964	(2,423)	12
	42,647	(34,615)	(5,469)	(270,877)(6)	(276,346)	(5,469)	(271,093)	(276
	(11,750)	(23,311)	(888)	323,823 (6)	322,935	(888)	332,003	(331
nts	101,095	67,834	76,441	110,085	110,085	76,441	58,487	58
	132,420	142,674	157,350	591,838	591,838	157,350	544,912	544
ties	6,175	5,475	5,358	188,526	188,526	5,358	196,231	196
equity	22,969	55,435	58,141	260,544	260,544	58,141	242,181	242

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	Predecessor		Predecessor	HealthSpring, Inc.		Predecessor	HealthSpring, Inc.		Heal
	Year Ended December 31,		Period from January 1, 2005 to	Period from March 1, 2005 to	Combined Twelve Months Ended	Period from January 1, 2005 to	Period from March 1, 2005 to	Combined Six Months Ended	M E
	2003(1)	2004(2)	February 28, 2005(3)	December 31, 2005(3)	December 31, 2005(4)	February 28, 2005(3)	June 30, 2005(3)	June 30, 2005(5)	Ju
	(Dollars in thousands, except share and unit data)								
g Statistics:									
ss ratio									
Advantage(7)	78.06%	78.07%	78.65%	78.33%	78.38%	78.65%	79.78%	79.43%	
ss ratio									
al(7)	86.17%	85.25%	78.79%	85.51%	84.41%	78.79%	85.31%	83.14%	
ss ratio									
neral and tive expense	13.57%	11.49%	12.28%	13.18%	13.06%	12.28%	12.15%	12.19%	
Medicare (9)	47,899	63,792	69,236	101,281	101,281	69,236	78,825	78,825	
Commercial(9)	54,280	48,380	40,523	41,769	41,769	40,523	41,397	41,397	
PDP(9)									

(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 $438.6 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 $0.0 million and $4.0 million of transaction costs that were expensed during the four-month period ended June 30, 2005 and the ten-month period ended December 31, 2005, respectively. 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 twelve-month period ended December 31, 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 December 31, 2005. The combined financial information is for illustrative purposes only, reflects the combination of the two-month period and the ten-month period to provide a comparison with the prior twelve-month periods reflected in the table, and is not presented in accordance with U.S. generally accepted accounting principles, or GAAP.

(5) The combined financial information for the six months ended June 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 June 30, 2005. The combined financial information is for illustrative purposes only, reflects the combination of the two-month period and the four-month period to provide a comparison with the comparable six-month period in 2006, and is not presented in accordance with GAAP.

(6) A substantial portion of the cash flows for investing and financing activities for the ten-month period ended December 31, 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.

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RISK FACTORS

Any investment in the 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 the 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 the 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.

Medicare premiums, including premiums from our PDP plans in 2006, accounted for approximately 87.2% and 82.4% of our total revenue for the six months ended June 30, 2006 and the combined twelve-month period ended December 31, 2005, respectively. As a result, our revenue and profitability are dependent on government funding levels for Medicare programs. The premium rates paid to Medicare 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, including prescription drug costs, and 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 which in turn would reduce our revenues and profitability.

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

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

Payments to Medicare Advantage plans are also adjusted by a budget neutrality factor that was implemented in 2003 by Congress and CMS to prevent health plan payments from being reduced overall while, at the same time, directing risk adjusted payments to plans with more chronically ill enrollees. In general, this adjustment has favorably impacted payments to all Medicare Advantage plans. In February 2006, the President signed legislation that reduces federal

funding for Medicare Advantage plans by

approximately $6.5 billion over five years. Among other changes, the legislation provides for an accelerated phase-out of budget neutrality for risk adjusted payments made to Medicare Advantage plans. 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 in a manner sufficient to offset the elimination of this adjustment. 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 Records May Contain Inaccurate Information Regarding the Risk Adjustment Scores of Our Members, Which Could Cause Us to Overstate or Understate Our Revenue.

We maintain claims and encounter data that support the risk adjustment scores of our members, which determine, in part, the revenue to which we are entitled for these members. This data is based on medical charts and diagnosis codes prepared by providers of medical care and is submitted to CMS twice a year. Inaccurate coding by medical providers and inaccurate records for new members in our plans could result in inaccurate premium revenue and risk adjustment payments, which is subject to correction or update in later periods. Payments that we receive in connection with this corrected or updated information may be reflected in financial statements for periods subsequent to the period in which the revenue was earned. We may also find that our data regarding our members risk adjustment scores, when reconciled, requires that we refund a portion of the revenue that we received in connection with our initial claims.

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 became effective in 2006 and, as a result, we are still assessing the impact of these changes. 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 new competitors, such as pharmacy benefits managers and prescription drug retailers and wholesalers, have established PDPs that compete 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 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 that treats regional plan enrollees. There can be no assurance that regional Medicare PPOs and private fee-for-service

plans in our service areas will not in the future adversely affect our Medicare Advantage plans relative attractiveness to existing and potential Medicare members.

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

Medicare beneficiaries generally have a limited annual enrollment period during which they can choose to participate in a Medicare Advantage plan rather than 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 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 unclear whether the governmental payments will continue to be adequate to cover our actual costs for these new MA-PD benefits or 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 offered with our Medicare Advantage plans. Our PDP or MA-PD benefits may not be as or more attractive than those of our competitors.

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Additionally, Medicare beneficiaries that participate in a Medicare Advantage plan that enroll in a PDP are automatically disenrolled from their Medicare Advantage plan. Moreover, in 2006, there has been substantial confusion among Medicare members regarding their opportunity to select Part D prescription drug benefits under the new legislation, which has been exacerbated by the proliferation and complexity of drug benefits offered by various Part D vendors and CMS enrollment reconciliation and systems issues. We believe the implementation of Part D has resulted in some of our members intentionally or inadvertently disenrolling from our MA-PDs and PDPs.

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 depends 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.

The absence of definitive accounting and regulatory guidance regarding the proper method of accounting for Medicare Part D, particularly as it relates to the timing of revenue and expense recognition, taken together with the complexity of the Part D product and the current challenges in reconciling CMS Part D membership data with our records, will lead to differences in our reporting of quarter-to-quarter earnings and may lead to uncertainty among investors and research analysts following the company as to the impacts of our MA-PDs and PDPs on our full year results.

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 existing members and attract new members.

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 HMO 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 statutory capital 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, on a national basis, we may be required to maintain additional statutory capital. In either case, our available funds could be materially reduced, which could harm our ability to implement our business strategy. See Management s Discussion and Analysis of Financial Condition and Results of Operations Cash Flows From Investing and Financing Activities Statutory Capital Requirements.

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 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. Historically, we have not relied on dividends or other distributions from our health plans to fund a material amount of our operating cash requirements. 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, however, 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 indebtedness to fund these strategies.

Corporate Practice of Medicine and Fee-Splitting Laws May Govern Our Business Operations, and Violation of Such Laws Could Result in Penalties and Adversely Affect Our Arrangements With Contractors and Our Profitability.

Numerous states, including Tennessee and Illinois, have laws known as the corporate practice of medicine laws that prohibit a business corporation from practicing medicine, employing physicians to practice medicine, or exercising control over medical treatment decisions by physicians. In these states, typically only medical professionals or a professional corporation in which the shares are held by licensed physicians or other medical professionals may provide medical care to patients. Many states also have some form of fee-splitting law, prohibiting certain business arrangements that involve the splitting or sharing of medical professional fees earned by a physician or another medical professional for the delivery of health care services.

We perform only non-medical administrative and business services for physicians and physician groups. We do not represent that we offer medical services, and we do not exercise control over the practice of medical care by providers with whom we contract. We do, however, monitor medical services to ensure they are provided and reimbursed within the appropriate scope of licensure. In addition, we have developed close relationships with our network providers that include our review and monitoring of the coding of medical services provided by those providers. We also have compensation arrangements with providers that may be based on a percentage of certain provider fees and in certain cases our network providers have agreed to exclusivity arrangements. In each case, we believe we have structured these and other arrangements on a basis that complies with applicable state law, including the corporate practice of medicine and fee-splitting laws.

Despite our structuring these arrangements in ways that we believe comply with applicable law, regulatory authorities may assert that we are engaged in the corporate practice of medicine or that our contractual arrangements with providers constitute unlawful fee-splitting. Moreover, we cannot predict whether changes will be made to existing laws or if new ones will be enacted, which could cause us to be out of compliance with these requirements. If our arrangements are found to violate corporate practice of medicine or fee-splitting laws, our provider or independent physician association management contracts could be found legally invalid and unenforceable, which could adversely affect our operations and profitability and we could be subject to civil, or in some cases criminal, penalties.

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 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.

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We 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 and PDPs 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 and PDPs or by contracts with our commercial customers, all of which are typically renewable on an annual basis. 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. 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;

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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 Would 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 would 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, Particularly New Sources of Competition Since the Implementation of Medicare Part D, 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 have traditionally been comprised of national, regional, and local managed care organizations that serve Medicare recipients, including, among others, UnitedHealth Group, Humana, Inc., and Universal American Financial Corp. In addition, as a result of the advent of Medicare Part D on January 1, 2006, we have experienced significant competition from new competitors, including pharmacy benefit managers and prescription drug retailers and wholesalers, and our traditional managed care organization competitors whose stand-alone PDPs have been attracting our Medicare Advantage and PDP members. As a result of the foregoing factors, among others, we have experienced disenrollments from our plans during 2006 at rates higher than we previously experienced or anticipated. Many managed care companies and other new Part D plan participants 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 than us. Our failure to maintain or attract members to our health plans as a result of such competition could adversely affect our results of operations.

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

A reduction in the number of members in our Medicare Advantage and PDP 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 plans;
- negative publicity and news coverage relating to us or the managed healthcare industry generally;
- litigation or threats of litigation against us;
- automatic disenrollment, whether intentional or inadvertent, 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 30% and 29% of our Medicare Advantage members and 30% and 29% of our total revenue as of and for the six months ended June 30, 2006 and the combined twelve month period ended December 31, 2005, 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 June 30, 2006, 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 Texas 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 a material disruption in care of our Houston-area 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.

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

As a result in part of the implementation of Part D, in early 2006 CMS s information and reporting systems generated confusing and, we believe in some cases, erroneous membership and payment reports concerning Medicare eligibility and enrollment. These developments caused our plans to experience short-term disruptions in their operations and challenged our information and communications systems. The enrollment errors also caused significant confusion among Medicare beneficiaries as to their participation in our or others Medicare Advantage plans. Moreover, we experienced a reallocation of administrative resources and incurred unanticipated administrative expenses dealing with this confusion. Although we believe these conditions have improved, there can be no assurance that the confusion, systems failures, and mistaken membership and payment reports will not continue to disrupt or adversely affect our plans relationships with our members or our results of operations.

CMS s Recently Announced Plan-to-Plan Reconciliation Process May Not Result in the Recovery of Non-Member Medical Expenses Borne by the Company.

We have incurred Part D medical expenses on behalf of Medicare beneficiaries who were not members of our PDPs. CMS has established a plan-to-plan, or P2P, reconciliation process for dates of service between January 1 and April 30, 2006 to address this condition and provide a means for reimbursement of some or all of these costs by the plan receiving premiums for these beneficiaries. Based on preliminary exchanges of data files between managed care plans, we estimate that we have incurred approximately $8.5 million of costs that are potentially recoverable under the current P2P reconciliation process. The P2P reconciliation process is specific regarding the format for the submission of data files. We currently estimate that, of the $8.5 million in total drug costs mentioned above, we currently have data files in the format prescribed by CMS to support claims of approximately $5.0 million. We have also received preliminary claims data (which may or may not be supportable in the CMS-prescribed data format) from other plans aggregating approximately $2.7 million. In connection with this process, we estimated and recorded a net receivable as of June 30, 2006 of $3.8 million and reduced medical expenses during the quarter ended June 30, 2006 by the same amount.

Although we are participating in the P2P reconciliation process, there can be no assurance that the CMS process will result in the recovery by us of any amounts payable to us on behalf of members of other plans or that we will not receive claims for reimbursement from other plans. Moreover, although we continue to develop files to support additional P2P reconciliation claims, there is no assurance that we will be able to produce complete files in the prescribed CMS format. Ultimate resolution of the P2P reconciliation process could result in adjustments, up or down, to the net amount currently estimated and recoverable.

We Rely on the Accuracy of Lists Provided by CMS Regarding the Eligibility of a Person to Participate in Our Plans, and Any Inaccuracies in Those Lists Could Cause CMS to Recoup Premium Payments From Us with Respect to Members Who Turn Out Not to be Ours, Which Could Reduce Our Revenue and Profitability.

Premium payments that we receive from CMS are based upon eligibility lists produced by federal and local governments. From time to time, CMS requires us to reimburse them for premiums that we received from CMS based on eligibility and dual eligibility lists that CMS later discovers contained individuals who were not in fact residing in our service areas or eligible for any government-sponsored program or were eligible for a different premium category or a different program. We may have already provided services to these individuals. In addition to recoupment of premiums previously paid,

we also face the risk that CMS could fail to pay us for members for whom we are entitled to payment. Our profitability would be reduced as a result of such failure to receive payment from CMS if we had made related payments to providers and were unable to recoup such payments from them.

Outsourced Service Providers May Make Mistakes and Subject Us to Financial Loss or Legal Liability.

We outsource certain of the functions associated with the provision of managed care and management services. The service providers to whom we outsource these functions could inadvertently or incorrectly adjust, revise, omit or transmit the data with which we provide them in a manner that could create inaccuracies in our risk adjustment data, cause us to overstate or understate our revenue, cause us to authorize incorrect payment levels to members of our provider networks, or violate certain laws and regulations, such as HIPAA.

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

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

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

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

For all of the above reasons, we may not be able to successfully implement our acquisition strategy. Furthermore, in the event of an acquisition or investment, we may issue stock that would dilute existing 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.

Our Acquisition of AHC is Subject to Regulatory Approval and Additional Due Diligence and May Not be Consummated on the Terms Agreed or At All.

In addition to the normal risks associated with acquiring another company and integration of that company s operations with those of HealthSpring, the consummation of our announced agreement to acquire AHC is subject to a number of other risks and uncertainties, including:

- the federal and Florida regulatory approval processes and the termination of CMS marketing and enrollment sanctions on AHC s operations;
- our ability to identify and manage risks and potential liabilities in our due diligence review of the books, records, and operations of AHC and its affiliates, including existing disputes and other contingent liabilities associated with the operation of AHC and its affiliated medical clinics;
- AHC s and the clinics claims files, and the adequacy and accuracy of the support for AHC s current risk scores;
- our inexperience in the Florida market in general and with AHC s provider network in particular; and
- if we do not exercise our option to purchase AHC s affiliated medical clinics, the ability of the AHC affiliates to operate the medical clinics in accordance with the agreements between AHC and the medical clinics.

In connection with our due diligence review of AHC and its affiliates, we have recently identified certain areas of concern relating to AHC and its affiliates, including the medical clinics. We have made AHC aware of these concerns. Our and AHC s review of these issues is in the preliminary stages and there is no definitive timetable for resolving these issues. We previously anticipated that the acquisition would close near the end of the third quarter or the beginning of the fourth quarter of 2006. Because of these recent developments, however, no assurance can be given that our acquisition of AHC will be completed at all or, if it is completed, when the acquisition would close or whether

the acquisition will be on the terms currently contemplated.

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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 who have been instrumental in developing our business strategy and forging our business relationships. Although certain of our executives, including Mr. Fritch, 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 Mr. Fritch and our other executive officers could adversely affect our business. J. Murray Blackshear, our Executive Vice President and President Tennessee Division and Pasquale R. Pingitore, M.D., our Senior Vice President and Chief Medical Officer have each informed us that they intend to retire effective December 31, 2006. There can be no assurance that we will be able to replace any of our executive officers with persons of comparable experience and ability, and it may take an extended period of time to replace them 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 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. Some of these providers do not have malpractice insurance. 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 of improper marketing practices by our independent and employee sales agents and 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 future lawsuits or indemnifying third parties with respect to the results of such litigation. The loss of even one of these claims, if it results in a significant damage award, could have a material adverse effect on our business. In addition, our exposure to potential liability under punitive damage or other theories may significantly decrease our ability to settle these claims on reasonable terms.

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

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

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

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

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

Risks Related to the Offering

Market Volatility May Affect Our Stock Price and the Value of Your Investment Following this Offering.

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 the common stock:

- Medicare budget decreases or changes in Medicare premium levels or reimbursement methodologies;
- regulatory or legislative changes;
- changes in expectations of our future membership growth or future financial performance or changes in financial estimates, if any, of public market analysts;
- 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;
- sales of large blocks of the common stock;

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

changes in accounting principles; and

the loss of any of our key management personnel.

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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 the 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 the Common Stock.

As a result of our recently completed IPO, we are required to enhance and test our financial, internal, and management control systems to meet 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 filing of our Annual Report on Form 10-K for the 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 the 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.

Under Our Amended and Restated Certificate Of Incorporation, 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, GTCR, the directors, officers, stockholders, members, managers, employees, and affiliates of 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.

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State Insurance Laws and 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 of state laws and 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 of our organizational documents 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 662/3% of our outstanding shares;
- our board of directors is 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 662/3% 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.

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

Additionally, the insurance company laws and regulations of the jurisdictions in which we operate restrict the ability of any person to acquire control of an insurance company, including an HMO, without prior regulatory approval. Under certain of those statutes and regulations, without such approval or an exemption therefrom, no person may acquire any voting security of a domestic insurance company, including an HMO, or an insurance holding company that controls a domestic insurance company or HMO, if as a result of such transaction such person would own more than a specified percentage, such as 5% or 10%, of the total stock issued and outstanding of such insurance company or HMO, or, in some cases, more than a specified percentage of the issued and outstanding shares of an insurance holding company. HealthSpring is an insurance holding company for purposes of these statutes and regulations.

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

After this offering, we will have outstanding 57,236,883 shares of common stock, substantially all of which, other than as set forth below, can be sold in the open market. Each of our executive officers and directors and each of the selling stockholders, who in the aggregate will own 17,600,778 shares of common stock following this offering (16,250,778 shares assuming the underwriters option to purchase an additional 1,350,000 shares of common stock has been exercised) have agreed, subject to specified exceptions, that without the prior written consent of each of Goldman, Sachs & Co., Citigroup Global Markets Inc., and UBS Securities LLC, 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 90 days from the date of this prospectus. Each of Goldman, Sachs & Co., Citigroup Global Markets Inc., and UBS Securities LLC, may, in their sole discretion, permit early release of shares subject to the lock-up agreements. For a further description of the lock-up arrangements 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.

Shares of common stock that are authorized for issuance under our 2006 equity incentive plan and shares issuable upon the exercise of options outstanding under our 2005 stock option plan 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 subject to the 90 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 holding an aggregate of 16,458,550 shares of common stock 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 the common stock in the public market could occur at any time. These sales could reduce the market price of the common stock.

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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, inte may, plans, potential, predicts, projects, should, will, would, and similar expressions intended to identif 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 from our Medicare Advantage plans who intentionally or inadvertently choose a competitor s stand-alone prescription drug plans;

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

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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.

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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 the 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 the 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 a 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. These borrowings were repaid in full in connection with our IPO in February 2006. 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. In connection with the IPO, the GTCR Funds sold 11,020,000 shares of common stock, thereby reducing their ownership to 23.9% of our outstanding common stock. Following this offering, the GTCR Funds will own approximately 9.95% of our outstanding shares of common stock, or 7.59% if the underwriters exercise their option to purchase an additional 1,350,000 shares of common stock.

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 was exchanged, without additional consideration, for 2,040,194 shares of the common stock immediately prior to the completion of our IPO in February 2006 in accordance with the organizational documents of Texas HealthSpring, LLC. Certain of these former minority owners in Texas HealthSpring, LLC are selling shares of common stock in this offering. See Principal and Selling Stockholders.

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USE OF PROCEEDS

All the shares of common stock in this offering are being sold by the selling stockholders. We will not receive any of the proceeds from the sale of common stock by the selling stockholders.

PRICE RANGE OF COMMON STOCK

The common stock has traded on the New York Stock Exchange under the symbol HS since our IPO on February 3, 2006. The company and the GTCR Funds sold shares of common stock in the IPO at a price per share of $19.50. Prior to the IPO, there was no public market for the common stock. The following table sets forth, for each of the periods listed, the high and low closing sales prices of the common stock, as reported by the New York Stock Exchange.

	High	Low
2006		
First Quarter ended March 31, 2006	$ 23.63	$ 17.50
Second Quarter ended June 30, 2006	$ 18.96	$ 15.66
Third Quarter (through September 15, 2006)	$ 22.30	$ 17.46

The last reported sale price of the common stock on the New York Stock Exchange on September 15, 2006 was $22.30 per share. As of September 15, 2006, there were approximately 255 holders of record of the common stock.

DIVIDEND POLICY

We have never declared or paid any cash dividends on the common stock. Our predecessor, which was a pass-through entity for tax purposes, made distributions to its members in the aggregate amount of $19.5 million in 2004. 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 senior revolving credit facility limits our ability to declare cash dividends on the common stock. As a holding company, 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 and PDPs. 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.

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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, 2004, and 2005 and for the period from January 1, 2005 to February 28, 2005 from the audited consolidated financial statements of NewQuest, LLC and the company, as applicable. The audited consolidated financial statements and the related notes to the audited consolidated financial statements of NewQuest, LLC and the company as of and for the years ended December 31, 2003, 2004, and 2005 together with the related reports of our independent registered public accounting firm are included elsewhere in this prospectus. We derived the selected balance sheet data as of 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 periods from March 1, 2005 (the effective date of the recapitalization of NewQuest, LLC) to June 30, 2005 and from January 1, 2006 to June 30, 2006 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 the company as of and for the period from March 1, 2005 to June 30, 2005 and the six months ended June 30, 2006 and of NewQuest, LLC as of and for the period from January 1, 2005 to February 28, 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.

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	Predecessor				HealthSpring, Inc.		Predecessor	HealthSpri Inc.
	Year Ended December 31,			Period from January 1, 2005 to February 28, 2005(5)	Period from March 1, 2005 to December 31, 2005(5)	Combined Twelve Months Ended December 31, 2005(6)	Period from January 1, 2005 to February 28, 2005(5)	Period fro March 1 2005 to June 30 2005(5)
)	2002(2)	2003(3)	2004(4)	(Dollars in thousands, except share and unit data)				
	$(8)	$ 240,037	$ 433,729	$ 94,764	$ 610,913	$ 705,677	$ 94,764	$ 208,5
	(8)	120,877	146,318	20,704	106,168	126,872	20,704	41,7
	24,939	360,914	580,047	115,468	717,081	832,549	115,468	250,2
976	1,099	11,054	17,919	3,461	16,955	20,416	3,461	6,8
43	78	695	1,449	461	3,337	3,798	461	1,0
019	26,116	372,663	599,415	119,390	737,373	856,763	119,390	258,1
	(8)	187,368	338,632	74,531	478,553	553,084	74,531	166,4
	(8)	104,164	124,743	16,312	90,783	107,095	16,312	35,5
	12,631	291,532	463,375	90,843	569,336	660,179	90,843	201,9
921	11,133	50,576	68,868	14,667	97,187	111,854	14,667	31,3
				6,941	4,000	10,941	6,941	
			24,200					
347	275	2,361	3,210	315	6,990	7,305	315	2,5
10	25	256	214	42	14,469	14,511	42	5,7
278	24,064	344,725	559,867	112,808	691,982	804,790	112,808	241,7
855	4,148	2,058	234		282	282		
	4,170							
596	10,370	29,996	39,782	6,582	45,673	52,255	6,582	16,4
050)	(1,315)	(5,519)	(6,272)	(1,248)	(1,979)	(3,227)	(1,248)	(4
546	9,055	24,477	33,510	5,334	43,694	49,028	5,334	16,0
	363	5,417	9,193	2,628	17,144	19,772	2,628	6,3
546	8,692	19,060	24,317	2,706	26,550	29,256	2,706	9,7

					15,607	15,607				6,0
546	$ 8,692	$ 19,060	$ 24,317	$ 2,706	$ 10,943	$ 13,649	$ 2,706	$ 3,6		
1.36	$ 2.13	$ 4.67	$ 5.31	$ 0.55			$ 0.55			
1.36	$ 2.13	$ 4.67	$ 5.31	$ 0.55			$ 0.55			
176	4,078,176	4,078,176	4,578,176	4,884,196			4,884,196			
176	4,078,176	4,078,176	4,578,176	4,884,196			4,884,196			
					$ 0.34			$ 0		
					$ 0.34			$ 0		
					32,173,707			32,069,5		
					32,215,288			32,069,5		
46	$ 190	$ 3,198	$ 2,512	$ 149	$ 2,653	$ 2,802	$ 149	$ 1,2		
488)	6,569	63,392	24,665	14,964	57,139	72,103	14,964	(2,4		
(46)	(6,123)	42,647	(34,615)	(5,469)	(270,877)(9)	(276,346)	(5,469)	(271,0		
250	5,748	(11,750)	(23,311)	(888)	323,823 (9)	322,935	(888)	332,0		
612	$ 6,806	$ 101,095	$ 67,834	$ 76,441	$ 110,085	$ 110,085	$ 76,441	$ 58,4		
941	37,559	132,420	142,674	157,350	591,838	591,838	157,350	544,9		
	4,958	6,175	5,475	5,358	188,526	188,526	5,358	196,2		
515	14,504	22,969	55,435	58,141	260,544	260,544	58,141	242,1		

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	Predecessor				HealthSpring, Inc.		Predecessor	HealthSpring, Inc.	
				Period from	Period from	Combined Twelve	Period from	Period from	Co
	Year Ended December 31,			January 1, 2005 to	March 1, 2005 to	Months Ended	January 1, 2005 to	March 1, 2005 to	M E
2001(1)	2002(2)	2003(3)	2004(4)	February 28, 2005(5)	December 31, 2005(5)	December 31, 2005(6)	February 28, 2005(5)	June 30, 2005(5)	Ju 2(
				(Dollars in thousands, except share and unit data)					
(8)	(8)	78.06%	78.07%	78.65%	78.33%	78.38%	78.65%	79.78%	
(8)	(8)	86.17%	85.25%	78.79%	85.51%	84.41%	78.79%	85.31%	
122.44%	42.63%	13.57%	11.49%	12.28%	13.18%	13.06%	12.28%	12.15%	
	33,560	47,899	63,792	69,236	101,281	101,281	69,236	78,825	
	53,605	54,280	48,380	40,523	41,769	41,769	40,523	41,397	

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

(2) 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.

(3) On April 1, 2003, TennQuest Health Solutions, LLC, or TennQuest, exercised an option to acquire an additional 33% interest in HealthSpring Management, Inc., or 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 the operations of 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.

(4) 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.

(5) 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 $438.6 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 $0.0 million and $4.0 million of transaction costs that were expensed during the four-month period ended June 30, 2005 and the ten-month period ended December 31, 2005, respectively. The transactions resulted in the Company recording $323.8 million in goodwill and $91.2 million in identifiable intangible assets.

(6) The combined financial information for the twelve-month period ended December 31, 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 December 31, 2005. The combined financial information is for illustrative purposes only, reflects the combination of the two-month period and the ten-month period to provide a comparison with the prior twelve-month periods reflected in the table, and is not presented in accordance with GAAP.

(7) The combined financial information for the six months ended June 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 June 30, 2005. The combined financial information is for illustrative purposes only, reflects the combination of the two-month period and the four-month period to provide a comparison with the comparable six-month period in 2006, 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 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 2001 and 2002.

(9) A substantial portion of the cash flows for investing and financing activities for the ten-month period ended December 31, 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 2001.

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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. As of June 30, 2006, we owned and operated Medicare health plans, including stand-alone prescription drug plans, in Tennessee, Texas, Alabama, Illinois, and Mississippi. For the six months ended June 30, 2006, approximately 87.2% of our total revenue consisted of premiums we received from CMS pursuant to our Medicare contracts. Although we concentrate on Medicare plans, we also utilize our infrastructure and provider networks in Tennessee and Alabama to offer commercial health plans to individuals and employer groups.

On January 1, 2006, we began offering prescription drug benefits in accordance with Medicare Part D to our Medicare Advantage plan members, in addition to continuing to provide other medical benefits. We sometimes refer to these plans after January 1, 2006 collectively as Medicare Advantage plans and separately as MA-only (in other words, without prescription drug benefits) and MA-PD (with prescription drug benefits) plans. On January 1, 2006, we also began offering prescription drug benefits on a stand-alone basis in accordance with Medicare Part D. We refer to these as stand-alone PDP or PDP plans. Accordingly, as of January 1, 2006 we began reflecting our membership by distinguishing between Medicare Advantage and PDP plans in our financial results, including premium revenue and medical expense, by distinguishing between Medicare (without Part D) and Part D. We have filed an application with CMS to expand our stand-alone PDP program on a national basis in 2007.

In February 2006, we completed our initial public offering, or IPO, of shares common stock. In the IPO we issued 10.6 million shares of common stock at a price of $19.50 per share. We used the net proceeds of the IPO of approximately $188.8 million to repay all of our outstanding indebtedness, including accrued and unpaid interest and other expenses related to the IPO. In connection with the IPO, the minority interests in our Texas HMO subsidiary were exchanged for 2,040,194 shares of the common stock. In addition, as a result of the IPO, all of our outstanding shares of preferred stock and accrued but unpaid dividends automatically converted into shares of common stock at the IPO price. Upon completion of the IPO, we had 57,289,549 shares of common stock outstanding.

Recent Developments

Agreement to Acquire Florida Medicare HMO

We entered into an agreement in May 2006 to acquire all of the outstanding capital stock of America s Health Choice Medical Plans, Inc., or America s Health Choice or AHC, a Florida-licensed HMO currently operating Medicare Advantage health plans in the following seven counties in Florida Brevard, Broward, Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie. AHC has operated

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under regulatory sanctions issued by CMS in July 2005. Pending administrative review, CMS temporarily lifted marketing and enrollment restrictions on May 1, 2006. For the three months ended June 30, 2006, we recognized $0.9 million of fee revenue relating to its management agreement referenced below. For the year ended December 31, 2005, America s Health Choice reported approximately $150.0 million in revenue and, as of June 30, 2006, had approximately 13,000 enrolled Medicare Advantage members and approximately 800 members in its stand-alone PDP plan.

Pursuant to the terms of the purchase agreement, we would pay the stockholders of America s Health Choice $50.0 million in cash, subject to an escrow for balance sheet adjustments and post-closing indemnification obligations, if any. An affiliate of AHC operates 33 medical clinics in and around the same seven county area, which provide medical services to AHC members. We also have an option to purchase the assets of the medical clinics in the event of the closing of the AHC acquisition. The option is exercisable at a formula purchase price subject to a minimum of $5.0 million. In connection with the agreement, a subsidiary of Healthspring entered into a separate agreement to manage the operations of AHC prior to closing the acquisition. The closing of the acquisition is subject to a number of usual and customary conditions, including the approval of CMS and Florida insurance regulators and our satisfactory completion of due diligence relating to the operations of AHC and its affiliates.

In connection with our due diligence review of AHC and its affiliates, we have recently identified certain areas of concern relating to AHC and its affiliates, including the medical clinics. We have made AHC aware of these concerns. Our and AHC s review of these issues is in the preliminary stages and there is no definitive timetable for resolving these issues. The acquisition agreement currently provides a general right of termination by either party if its conditions to closing have not been satisfied by October 31, 2006 and by either party if closing has not occurred by December 31, 2006. We previously anticipated that the acquisition would close near the end of the third quarter or the beginning of the fourth quarter of 2006. Because of these recent developments, however, no assurance can be given that our acquisition of AHC will be completed at all or, if it is completed, when the acquisition would close or whether the acquisition will be on the terms currently contemplated.

Retroactive Risk Adjustments

In July 2006, we were notified by CMS that our retroactive risk adjustment payment for our Medicare Advantage plans (not including Part D) through July was approximately $12.6 million, which payment will be reflected as additional premium in the quarter ending September 30, 2006, in accordance with our policy of recording such adjustments on an as-received basis. As a result of the risk adjustment payment, we expect a favorable after-tax impact on net income of approximately $6.3 million after risk sharing with providers and income taxes. In addition, the impact of the risk adjustments on Medicare Advantage (not including Part D) premiums for the balance of 2006 will be an increase over year-to-date average premiums of 1.5-2.0% which is similar to the amount of the premium increase in 2005 relating to the risk adjustment payment. Retroactive risk adjustment payments reflected as additional premium in the quarter ended September 30, 2005 equaled $8.2 million for the 2005 period through August. Additionally, we received risk adjustment payments in August 2005 of approximately $1.9 million and $1.1 million relating to prescription drug benefits provided by our MA-PD and PDP plans, respectively, which payments are subject to the Part D risk corridor adjustment.

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.

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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 the 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 the 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 to the members of NewQuest, LLC and to pay expenses and other payments relating to the transaction. These borrowings were repaid in full in connection with our IPO in February 2006. 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. In connection with the IPO, the GTCR Funds sold 11.02 million shares of common stock, thereby reducing their ownership to 23.9% of our outstanding common stock. Following this offering, the GTCR Funds will own approximately 9.95% of our outstanding shares of common stock, or 7.59% if the underwriters exercise their option to purchase an additional 1,350,000 shares of common stock.

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 $7.9 million. Following this private placement, and as of December 31, 2005, the outside investors owned an approximately 15.9% interest in Texas HealthSpring, LLC, which interest was automatically exchanged, without additional consideration, for 2,040,194 shares of the common stock immediately prior to the IPO. Certain of these former minority owners in Texas HealthSpring, LLC are selling shares of common stock in this offering. See Principal and Selling Stockholders.

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 $438.6 million, which included $5.3 million of capitalized acquisition related costs and $6.4 million of deferred financing costs. In addition, the company incurred $6.9 million of transaction costs that were expensed during the two-month period ended February 28, 2005 and $4.0 million of costs that were expensed during the ten-month period ended December 31, 2005. As a result of the recapitalization, the company acquired $438.6 million of net assets, including $91.2 million of identifiable intangible assets and goodwill of approximately $315.1 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 two 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 six-month results with the comparable 2006 period, we have combined the results of operations of the predecessor from January 1, 2005 through

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February 28, 2005 and of the company for March 1, 2005 through June 30, 2005. For purposes of comparing our 2006 six-month results with the comparable 2005 period and 2005 twelve-month results with the comparable 2004 and 2003 periods, we have combined the results of operations of the predecessor from January 1, 2005 through February 28, 2005 and of the company for the period from March 1, 2005 through June 30, 2005 and through December 31, 2005, respectively. These combined presentations are not in accordance with GAAP; however, we believe they are useful in analyzing and comparing certain of our operating trends for the six month ended June 30, 2005 and June 30, 2006 and for the years ended December 31, 2003, 2004 and 2005. The combined and consolidated results of operations include the accounts of HealthSpring, Inc. and all of its subsidiaries. Significant intercompany accounts and transactions have been eliminated.

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 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 plans submits rate proposals to CMS, generally by county or service area, in June for each Medicare product that will be offered beginning January 1 of the subsequent year. 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 because they are not estimable. These rate adjustments are recorded as received. Our commercial premiums are generally fixed for the plan year, in most cases beginning January 1.

To participate in Part D, we were required to provide written bids to CMS, which among other items, included the estimated costs of providing prescription drug benefits. Premium payments from CMS are based on these estimated costs. The amount of CMS payments relating to the Part D standard coverage for our MA-PD and PDP plans is subject to adjustment, positive or negative, based upon the application of risk corridors that compare our prescription drug costs in our bids to CMS to our actual prescription drug costs. Variances exceeding certain thresholds may result in CMS making additional payments to us or our refunding to CMS a portion of the premium payments we previously received. We estimate and recognize adjustments to premium revenue related to estimated risk corridor payments based upon our actual prescription drug cost for each reporting period as if the annual contract were to end at the end of each reporting period.

Certain Part D payments from CMS represent payments for claims we pay for which we assume no risk, including reinsurance and low-income cost subsidies. We account for these subsidies as funds held for the benefit of members on our balance sheet and as a financing activity in our statement of cash flows. We do not recognize premium revenue or claims expense for these subsidies as these amounts represent pass-through payments from CMS to fund deductibles, co-payments and other member benefits. We recognize prescription drug costs as incurred, net of rebates

from drug companies. We have subcontracted the prescription drug claims administration to a third party pharmacy benefits manager.

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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 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. Management fees calculated based on profits are recognized, as fee revenue or as a credit to medical expenses, if applicable, 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.

Medical Expense

Our largest expense is the cost of medical services we arrange for our members, or medical expense. Medical expense for our Medicare 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 some or all of 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 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 expense, 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.

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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,			Six Months Ended June 30,	Six Months Ended June 30,
Revenue:	**2003**	**2004**	**2005** (Combined)	**2005** (Combined)	**2006**
Premium:					
Medicare premiums	64.4%	72.4%	82.4%	80.4%	87.2%
Commercial premiums	32.4	24.4	14.8	16.5	10.2
Total premiums	96.8	96.8	97.2	96.9	97.4
Fee revenue	3.0	3.0	2.4	2.7	1.9
Investment income	0.2	0.2	0.4	0.4	0.7
Total Revenue	100.0	100.0	100.0	100.0	100.0
Expenses:					
Medical expense	78.2	77.3	77.0	77.6	79.2
Selling, general and administrative expense	13.6	11.5	13.1	12.2	11.2
Transaction expense			1.3	1.8	
Phantom stock compensation		4.0			
Depreciation and amortization expense	0.6	0.6	0.8	0.8	0.8
Interest expense	0.1		1.7	1.5	1.3
Total expenses	92.5	93.4	93.9	93.9	92.5
Equity in earnings of unconsolidated affiliates	0.6				
Income before minority interest and income taxes	8.1	6.6	6.1	6.1	7.5
Minority interest	(1.5)	(1.0)	(0.4)	(0.4)	
Income before income taxes	6.6	5.6	5.7	5.7	7.5
Income tax expense	1.5	1.5	2.3	2.4	2.8
Net income	5.1	4.1	3.4	3.3	4.7
Preferred dividends			1.8	1.6	0.3
Net income available to members or common stockholders	5.1%	4.1%	1.6%	1.7%	4.4%

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Membership

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, stand-alone PDP, and commercial plan membership as of the dates indicated.

	December 31,			June 30,	
	2003	2004	2005	2005	2006
Medicare Advantage Membership(1)					
Tennessee	25,772	29,862	42,509	35,720	44,814
Texas	15,637	21,221	29,706	25,348	32,225
Alabama	6,490	12,709	24,531	16,014	24,669
Illinois(2)			4,166	1,743	5,518
Mississippi(3)			369		425
Total	47,899	63,792	101,281	78,825	107,651
Medicare Stand-Alone PDP Membership					88,139
Commercial Membership(4)					
Tennessee	32,668	32,139	29,859	29,018	28,810
Alabama	21,612	16,241	11,910	12,379	9,303
Total	54,280	48,380	41,769	41,397	38,113(5)

(1) Includes MA-only and MA-PD membership.

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

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

(4) 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.

(5) We expect a decrease of at least 10,000 commercial members beginning January 1, 2007 as a result of the discontinuation of coverage with two large employers in Tennessee. We also expect a decrease of 5,000 commercial members effective October 1, 2006 as a result of the discontinuation of coverage with a large employer in Alabama and expect Alabama commercial membership at December 31, 2006 to be under 3,000.

The annual enrollment and lock-in provisions of the Medicare Modernization Act of 2003 took full effect on June 30, 2006. After June 30, generally only seniors turning 65 (so called age-ins), Medicare beneficiaries who permanently relocate to another service area, and dual-eligible beneficiaries and others who qualify for special needs plans will be permitted to enroll in or change Medicare plans. Accordingly, we are currently focusing our sales, marketing, and enrollment efforts on persons not subject to lock-in.

Medicare Advantage. Our Medicare Advantage membership increased by 6.3% to 107,651 members at June 30, 2006 as compared to 101,281 members at December 31, 2005. The substantial majority of this increase was attributable to growth in membership in our existing core markets in Tennessee, Texas, Alabama and Illinois through increased penetration in existing service areas and geographic expansion into new counties contiguous to existing service areas.

Stand-Alone PDP. Stand-alone PDP membership was 88,139 at June 30, 2006. In connection with the initial implementation of Part D, effective as of January 1, 2006, HealthSpring received automatic assignments of approximately 90,000 PDP members. This initial membership declined as many of these auto-assigned members selected other Medicare plans, including other PDPs. On May 1, 2006, HealthSpring received additional automatic assignments of approximately 20,000 PDP members.

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Commercial. Our commercial HMO membership declined from 41,769 members at December 31, 2005 to 38,113 members at June 30, 2006, or by 8.8%, primarily as a result of our decision to increase premiums to maintain our commercial margins and the discontinuance of certain unprofitable customer and provider relationships in Alabama and Tennessee. We expect a decrease of 5,000 commercial members effective October 1, 2006 as a result of the discontinuation of coverage with a large employer in Alabama and expect Alabama commercial membership at December 31, 2006 to be under 3,000. We also expect a decrease of at least 10,000 commercial members beginning January 1, 2007 as a result of the discontinuation of coverage with two large employers in Tennessee.

Comparison of the Six-Month Period Ended June 30, 2006 to the Combined Six-Month Period Ended June 30, 2005

Revenue

Total revenue was $629.4 million in the six-month period ended June 30, 2006 as compared with $377.6 million for the same period in 2005, representing an increase of $251.8 million, or 66.7%. The components of revenue were as follows:

Premium Revenue: Total premium revenue for the six months ended June 30, 2006 was $613.1 million as compared with $365.8 million in the same period in 2005, representing an increase of $247.4 million, or 67.6%. The components of premium revenue and the primary reasons for changes were as follows:

Medicare Advantage: Medicare premiums were $451.4 million in the six months ended June 30, 2006 versus $303.3 million in the prior year, representing an increase of $148.1 million, or 48.8%. The increase in Medicare Advantage premiums in 2006 is primarily attributable to the 44.0% increase in membership months to 626,469 for the six months ended June 30, 2006 from 435,155 for the comparable period of 2005. An increase in our average PMPM premium to $720.60 for the first six months of 2006 from $697.10 for the comparable 2005 period, or by 3.4%, also contributed to the increase in premium revenue. For the six months ended June 30, 2006, Medicare Advantage premiums represented 73.6% of total premium revenue and 71.7% of total revenue, as compared with 82.9% and 80.3%, respectively, for the prior year comparable period. This percentage decline is primarily the result of Medicare Part D premiums that we began receiving as of January 1, 2006.

Medicare Part D: Medicare Part D premiums were $97.6 million in the six months ended June 30, 2006. Our average PMPM premiums received from CMS were $86.94 for MA-PD members and $104.60 for stand-alone PDP members for the six months ended June 30, 2006. For the six months ended June 30, 2006, Medicare Part D premiums represented 15.9% of total premium revenue and 15.5% of total revenue.

Commercial: Commercial premiums were $64.1 million in the six months ended June 30, 2006 as compared with $62.4 million in the 2005 comparable period, reflecting an increase of $1.7 million, or 2.7%. The increase was attributable to an average commercial premium increase of approximately 7.6%, offset by the decline in membership. For the first six months of 2006, commercial premiums represented 10.5% of total premium revenue and 10.2% of total revenue versus 17.1% and 16.5%, respectively, for the prior year. Because of the expansion of our Medicare program, continuing Medicare member growth in existing service areas, our decision to exit the individual and small employer group commercial markets in Alabama, the anticipated loss of a large employer customer in Alabama, and the implementation of Medicare Part D, 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 $11.7 million in the first six months of 2006 as compared with $10.3 million in the comparable period of 2005, representing an increase of $1.4 million, or 13.8%.

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The increase was primarily attributable to the addition of the new management agreement with AHC and growth in membership, partially offset by decreases in other fee revenue.

Investment Income. Investment income was $4.6 million for the first six months of 2006 versus $1.5 million for the comparable period of 2005, reflecting an increase of $3.1 million, or 203.9%. The increase is attributable primarily to an increase in average invested and cash balances, coupled with a higher average yield on these balances.

Medical Expense

Medicare Advantage. Medicare Advantage medical expense for the six months ended June 30, 2006 increased $113.0 million, or 46.9%, to $353.9 million from $240.9 million for the comparable period of 2005, primarily as a result of increased membership. For the six months ended June 30, 2006, Medicare Advantage MLR was 78.40% versus 79.43% for the same period of 2005, although these statistics are not fully comparable as the prior year comparable period includes prescription drug costs that are now covered by and accounted for in Medicare Part D. The improvement is primarily attributable to improvements in medical cost trends, a lighter flu season and favorable prior period reserve developments offset by higher than anticipated medical expense in our Tennessee HMO, including an accrual of $4.2 million of medical expense (of which $3.8 million was recorded as Medicare medical expense) in connection with the settlement with a middle Tennessee hospital system. Our Medicare Advantage medical expense calculated on a PMPM basis was $564.93 for the six months ended June 30, 2006, compared with $553.68 for 2005, reflecting an increase of 2.03%.

Medicare Part D. Medicare Part D medical expense for the six months ended June 30, 2006 was $88.0 million reflecting an MLR of 90.16%. Because of the Part D product benefit design, HealthSpring incurs prescription drug costs unevenly throughout the year, including a disproportionate amount of prescription drug costs in the first half of the year. Part D expense includes prescription drug costs for members of other Part D plans. These amounts, net of related drug manufacturers rebates and a $3.8 million receivable for non-member drug costs in connection with CMS s process for plan-to-plan reconciliation, have been reflected in the statement of income as Part D medical expense.

Commercial. Commercial medical expense increased by $4.5 million, or 8.6%, to $56.4 million for the first six months of 2006 as compared to $51.9 million for the same period of 2005. The commercial MLR was 87.92% for the first six months of 2006 as compared with 83.14% in the same period in 2005, an increase of 478 basis points, which was primarily attributable to an unusually large number of high dollar in-patient cases during the 2006 second quarter combined with approximately $400,000 accrued on behalf of the commercial line of business relating to the settlement with the middle Tennessee hospital system discussed above.

Selling, General, and Administrative Expense

SG&A expense for the six months ended June 30, 2006 was $70.6 million as compared with $53.0 million for the same prior year period, an increase of $17.6 million, or 33.2%. The prior period amount includes transaction expenses of $6.9 million as incurred in conjunction with the recapitalization.

The increase in SG&A expense was attributable, in part, to an increase in personnel, including increases in corporate personnel in connection with the IPO and to support the implementation of Part D, increased sales commissions resulting from the increased membership, the recognition of stock compensation expense in connection with the adoption of SFAS No. 123R effective as of January 1, 2006 and other spending associated with supporting and sustaining our membership growth, including expansion into new geographic areas. As a percentage of revenue, SG&A expense was 11.2% for the first six months of 2006 as compared with 12.2% for the same prior year period.

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Depreciation and Amortization Expense

Depreciation and amortization expense was $4.9 million in the six months ended June 30, 2006 as compared with $2.9 million in the same combined period of 2005, representing an increase of $2.0 million, or 68.4%. The increase is primarily attributable to the amortization of identifiable intangible assets recorded in conjunction with the recapitalization. Amortization related to the recapitalization in the amount of $3.8 million was recorded during the first six months of 2006 as compared with $1.9 million in the first six months of 2005. Amortization in 2006 includes approximately $0.8 million as a result of the accelerated write-off of recorded intangibles for customer relationships in Alabama. We are writing down these intangibles in anticipation of expected decreases in membership in Alabama.

Interest Expense

Interest expense was $8.5 million in the six-month period ended June 30, 2006 as compared with $5.8 million in the same combined period of 2005. Most of our interest expense in 2006 related to the write-off of deferred financing costs in the amount of $5.4 million and an early pay-off penalty of $1.1 million related to the payoff of all our outstanding indebtedness and related accrued interest in February 2006 with proceeds from the IPO. Interest expense in 2005 related primarily to our indebtedness incurred in connection with the recapitalization.

Minority Interest

Minority interest was $0.3 million in the six months ended 2006 as compared with $1.7 million in the same combined period of 2005. The change is attributable to the inclusion of minority interest ownership in our Tennessee HMO and management subsidiaries and a higher minority interest ownership in our Texas HMO subsidiary for the two months of 2005 prior to the recapitalization. Contemporaneously with the recapitalization, we purchased all of the minority interests in the Tennessee subsidiaries. In conjunction with the IPO in February 2006, all minority interest ownership in the Texas HMO subsidiary was exchanged for the common stock.

Income Tax Expense

For the six months ended June 30, 2006, income tax expense was $17.5 million, reflecting an effective tax rate of 37.1%, versus $8.9 million, reflecting an effective tax rate of 41.8%, for the same combined period of 2005. The higher effective tax rate in 2005 was the result of losses at several of our subsidiaries, which are consolidated for accounting purposes, not being available for tax purposes given such subsidiaries prior status as pass-through entities for tax purposes.

Preferred Dividend

In the six months ended June 30, 2006, we accrued $2.0 million of dividends payable on the preferred stock issued in connection with the recapitalization as compared to a dividend accrued in the same combined period in 2005 of $6.1 million for the four months following the recapitalization. In February 2006, in connection with the IPO, the preferred stock and all accrued and unpaid dividends were converted into common stock.

Comparison of the Combined Twelve Month Period Ended December 31, 2005 to the Year Ended December 31, 2004

Membership

Our Medicare Advantage membership increased by 58.8% to 101,281 members at December 31, 2005 as compared to 63,792 members at December 31, 2004. The substantial majority 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. Enrollment efforts in our new markets, Illinois and Mississippi, which commenced in December 2004 and July 2005, respectively, also contributed to the increase. Our commercial HMO membership declined by 13.7% over the same period, from 48,380 to 41,769, primarily as a result of our decision to increase premiums to maintain our commercial margins and the discontinuance of certain unprofitable customer and provider relationships in Alabama and Tennessee.

Revenue

Total revenue was $856.8 million in the combined twelve months of 2005 as compared with $599.4 million for 2004, representing an increase of $257.4 million, or 42.9%. The components of revenue were as follows:

Premium Revenue. Total premium revenue for the combined twelve months of 2005 was $832.5 million as compared with $580.0 million in 2004, representing an increase of $252.5 million, or 43.5%. The components of premium revenue and the primary reasons for changes were as follows:

Medicare: Medicare premiums were $705.7 million in the combined twelve months of 2005 versus $433.7 million in the prior year, representing an increase of $272.0 million, or 62.7%. The primary factors affecting changes in Medicare premium revenue include membership (which we measure in member months), premium 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 46.1% increase in membership months to 996,929 for the combined twelve months of 2005 from 682,331 for the comparable period of 2004. An increase in our average PMPM premium to $707.85 for the combined twelve months of 2005 from $635.66 for 2004, or by 11.4%, also contributed to the increase in premium revenue. Approximately $9.8 million, or $9.82 PMPM, of the rate increase was attributable to retroactive risk payments received from CMS during the combined twelve months ended December 31, 2005. For the combined twelve months of 2005, Medicare premiums represented 84.8% of total premium revenue and 82.4% of total revenue as compared with 74.8% and 72.4%, respectively, for the comparable period of the prior year.

Commercial: Commercial premiums were $126.9 million in the combined twelve months of 2005 as compared with $146.3 million in 2004, reflecting a decrease of $19.4 million, or 13.3%. The decline in commercial premiums is attributable to the decline in commercial membership months to 497,973 for the combined twelve month period ended December 31, 2005 from 614,295 for 2004, or by 18.9%, which was partially offset by average commercial premium increases of approximately 7.0% over the same period. For the combined twelve months of 2005, commercial premiums represented 15.2% of total premium revenue and 14.8% of total revenue versus 25.2% and 24.4%, respectively, for the prior year. Because of our expansion of our Medicare program 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 as of January 1, 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 $20.4 million in the combined twelve months of 2005 as compared with $17.9 million in 2004, representing an increase of $2.5 million, or 13.9%. 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, and the increase in Medicare Advantage membership.

Investment Income. Investment income was $3.8 million for the combined twelve months of 2005 versus $1.4 million for 2004, reflecting an increase of $2.4 million, or 171.4%. The increase is

attributable primarily to an increase in average invested and cash balances, coupled with a higher average yield on these balances.

Medical Expense

Medicare medical expense for the combined twelve months ended December 31, 2005 increased $214.5 million, or 63.3%, to $553.1 million from $338.6 million for 2004, primarily as a result of increased membership. Commercial medical expense decreased by $17.6 million, or 14.2%, to $107.1 million for the combined twelve months of 2005 as compared to $124.7 million for 2004, primarily as a result of the decrease in commercial membership over the same period.

For the combined twelve months ended December 31, 2005, the Medicare MLR was 78.38% versus 78.07% for 2004, reflecting an increase of 31 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, offset in part by favorable Medicare premium rates. Our Medicare medical expense calculated on a PMPM basis was $554.79 for the combined twelve months ended December 31, 2005, compared with $496.29 for 2004, reflecting an increase of 11.8%, which was primarily attributable to a higher mix of dual-eligible beneficiaries in 2005. The commercial MLR was 84.41% for the combined twelve months of 2005 as compared with 85.25% in 2004, a decrease of 84 basis points, which was primarily attributable to improvement in commercial premiums and relatively flat cost trends.

Selling, General, and Administrative Expense

Selling, general, and administrative, or SG&A, expense for the combined twelve months ended December 31, 2005 was $111.9 million (not including the $10.9 million of transaction expense described below) as compared with $68.9 million for the prior year, an increase of $43.0 million, or 62.4%. As a percentage of revenue, SG&A expense was 13.06% for the combined twelve months of 2005 versus 11.49% for the prior year, an increase of 157 basis points. The increase in SG&A expense was attributable, in part, to an increase in personnel, including increases in corporate personnel in anticipation of the IPO, increased sales commissions resulting from the increased membership, 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 2005, the company incurred approximately $6.8 million of expense associated with this expansion activity. In addition, in 2005 we incurred approximately $4.0 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 and $1.7 million of stock compensation expense.

Transaction Expense

Transaction expense of $10.9 million was incurred in the combined twelve months of 2005 in conjunction with the recapitalization. This expense includes fees paid to financial and legal advisors and other expenses, including $4.0 million related to a settlement with RPO. See Notes 7 and 23 to our Consolidated Financial Statements for the year ending December 31, 2005 included elsewhere in this prospectus.

Depreciation and Amortization Expense

Depreciation and amortization expense was $7.3 million in the combined twelve months of 2005 as compared with $3.2 million in 2004, representing an increase of $4.1 million, or 128.1%. The

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increase is primarily attributable to the amortization of identifiable intangible assets recorded in conjunction with the recapitalization. Amortization related to the recapitalization in the amount of $5.0 million was recorded during the combined twelve months of 2005. Management currently expects that amortization relating to the identifiable intangible assets recorded in the recapitalization for 2006 will be approximately $7.3 million, which includes the acceleration of amortization of certain identifiable intangible assets as a result of our Alabama HMO s decision following the recapitalization to exit the individual and small employer commercial business.

Interest Expense

Interest expense was $14.5 million in the combined twelve months of 2005. Almost all of the company s interest expense related to the senior credit facility and senior subordinated notes put in place in conjunction with the recapitalization. For the combined twelve months ended December 31, 2005, we recorded interest expense of $9.0 million related to our senior credit facility and $4.5 million related to our senior subordinated notes. Additionally, interest expense in the combined twelve months of 2005 includes $0.9 million for amortization of deferred finance costs. The effective annual interest rate during the combined twelve months of 2005 on the senior credit facility was 6.6% and on the senior subordinated notes was 15%, 12% of which was payable in cash and 3% of which accrued quarterly and was added to the outstanding principal amount. In February 2006, in connection with the IPO, the company repaid all of its outstanding indebtedness and related accrued interest, and wrote off related deferred financing costs of $5.5 million.

Minority Interest

Minority interest was $3.2 million in the combined twelve months of 2005 as compared with $6.3 million in 2004. The change is attributable to the elimination of minority interest ownership in our Tennessee HMO and management subsidiaries and the reduction of minority interest ownership interest in our Texas HMO subsidiary 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 increases in ownership. In conjunction with the IPO, all minority interest ownership in the Texas HMO subsidiary was exchanged for their shares of our common stock.

Income Tax Expense

For the combined twelve months ended December 31, 2005, income tax expense was $19.8 million, reflecting an effective tax rate of 40.3%, versus $9.2 million, reflecting an effective tax rate of 27.4%, for 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 combined twelve months ended December 31, 2005, we accrued $15.6 million of dividends payable on the preferred stock issued in connection with the recapitalization. The $227.2 million liquidation value of preferred stock had an accumulating dividend of 8%, whether declared or paid. In February 2006, in connection with the IPO, the preferred stock and all accrued and unpaid dividends were automatically converted into common stock.

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

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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 therefore are best understood by comparing 2003 as adjusted to reflect HSMI on an as if consolidated basis for the first quarter of 2003 to 2004 as reported. 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	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
Income before equity in earnings of unconsolidated affiliates, minority interest, and income taxes	$ 27,938	$ 3,989	$ 31,927	$ 39,548
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

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.

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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.

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%

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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.

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.

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 were paid to members of our predecessor in exchange for their membership units or to others, primarily for expenses related to the recapitalization. All of our outstanding funded indebtedness was repaid in February 2006 with proceeds from the IPO. Although we eliminated our funded debt, we may borrow up to $75.0 million pursuant to our senior revolving credit facility, which amount may be increased by up to $50.0 million subject to certain conditions. See Indebtedness below.

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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 revolving credit facility will be sufficient to fund our working capital needs and anticipated capital expenditures over the next twelve months.

The reported changes in cash and cash equivalents for the years ended December 31, 2003 and 2004, the combined twelve-month period ended December 31, 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 December 31, 2005, and the six months ended June 30, 2006, are summarized below:

	Year Ended December 31,		Combined Twelve Months Ended December 31,	Six Months Ended
	2003	2004	2005	June 30, 2006
	(In thousands)			
Net cash provided by operating activities	$ 63,392	$ 24,665	$ 72,103	$ 134,456
Net cash (used in) provided by investing activities	42,647	(34,615)	(276,346)	(1,224)
Net cash provided by (used in) financing activities	(11,750)	(23,311)	322,935	76,888
Increase (decrease) in cash and cash equivalents	$ 94,289	$ (33,261)	$ 118,692	$ 210,120

Our investing and financing activities for the combined twelve months ended December 31, 2005 were significantly affected by the recapitalization.

Cash Flows from Operating Activities

Our cash flows are significantly influenced by the timing of the Medicare premium remittance from CMS, which is payable to us normally on the first day of each month. This payment is from time to time received in 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 2003, which had the effect of increasing operating cash flows in that year with a corresponding decrease in the following year. Similarly, the July 2006 payment in the amount of $94.7 million was received in June 2006, which had the effect of increasing operating cash flows in that month with a corresponding decrease in July 2006. Adjusting our operating cash flows in 2003 and 2004 and for the six months ended June 30, 2006 for the effect of the timing of this payment, our operating cash flows would have been as follows:

	Year Ended December 31,	Combined Twelve Months Ended December 31,	Six Months Ended

	2003	2004	2005	June 30, 2006
		(In thousands)		
Net cash provided by operating activities, as reported	$ 63,392	$ 24,665	$ 72,103	$ 134,456
Timing effect of CMS payment	(28,597)	28,597		(94,389)
Adjusted net cash provided by operating activities	$ 34,795	$ 53,262	$ 72,103	$ 40,067

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2005 Compared With 2004. The increase in adjusted cash flow provided by operating activities to $72.1 million for the combined twelve months ended December 31, 2005 as compared with $53.3 million for 2004 is primarily attributable to increases in membership and premiums. For the combined twelve months of 2005, we generated $29.3 million of net income and increased working capital by $33.1 million. Net income had been reduced as a result of depreciation and amortization in the amount of $7.3 million and minority interest of $3.2 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.

Cash Flows from Investing and Financing Activities

For the six months ended June 30, 2006, the primary investing activities consisted of $1.6 million in property and equipment additions, approximately $5.9 million used to purchase investments, and $7.3 million in proceeds from the sale and maturity of investment securities. During the first six months of 2006, our financing activities consisted of proceeds received from the issuance of common stock related to the IPO in February 2006 of $188.8 million, of which $188.6 million was used to pay off all outstanding indebtedness, and $77.7 million of funds received from CMS for the benefit of members.

For the combined twelve months ended December 31, 2005, the primary investing and financing activities related to the recapitalization. The company also had $2.8 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 in 2004.

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 satisfy minimum net worth requirements established by their respective state departments of insurance. The minimum net worth requirements are typically set by statute, although the state departments of insurance can require our HMO subsidiaries to maintain minimum levels of statutory capital in excess of the amount required by applicable law if they determine that it is in the best interests of our members.

For example, at June 30, 2006, our Alabama HMO subsidiary had statutory capital in excess of the statutory minimum of approximately $22.6 million; however, the Alabama Department of Insurance determined that it is in the best interests of our members in Alabama for the excess statutory capital to remain in the Alabama HMO subsidiary. As a result, the Alabama Department of Insurance has stated that it does not believe our Alabama HMO subsidiary had excess statutory capital at June 30, 2006. At June 30, 2006, our Texas and Alabama HMO subsidiaries were in compliance with applicable minimum net worth requirements. At June 30, 2006, our Tennessee HMO subsidiary had

a negative net worth of $1.7 million and was not in compliance with the applicable minimum net worth

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requirement of $9.6 million. The Tennessee HMO s net worth deficiency resulted primarily from losses during the quarter and the classification of certain assets, including pharmacy rebates and intercompany receivables, as non-admitted assets for statutory accounting purposes. In August 2006, we invested $12.0 million in additional cash, in the Tennessee HMO to remedy our non-compliance with state requirements.

The HMOs are restricted from making distributions without appropriate regulatory notifications and approvals or to the extent such distributions would put them out of compliance with applicable net worth requirements. At June 30, 2006, $339.9 million of our $371.5 million of cash, cash equivalents, investment securities and restricted investments were held by our HMO subsidiaries and subject to these dividend restrictions. In August 2006, our Texas HMO subsidiary distributed $30.0 million in cash to the parent company.

Indebtedness

In April 2006, HealthSpring, Inc. and certain of its non-HMO subsidiaries as guarantors entered into a senior revolving credit facility, which provides for borrowings of up to a maximum aggregate principal amount outstanding of $75.0 million, including a $2.5 million swingline subfacility and a maximum of $5.0 million in outstanding letters of credit. The obligations under our senior revolving credit facility are secured by all of our assets. We may request an expansion of the aggregate commitments under the senior credit facility up to a maximum of $125.0 million, subject to certain conditions precedent including the consent of the lenders providing the increased credit availability. Loans under the senior credit facility accrue interest on the basis of either a base rate or a LIBOR rate plus, in each case, an applicable margin depending on our leverage ratio. The applicable margin for base rate loans (including swingline loans) ranges from 0.00% to 0.75%, and the applicable margin for LIBOR loans ranges from 1.00% to 1.75%. We pay a fee of 0.375% per annum on the unfunded portion of the lenders aggregate commitments under the facility.

The senior credit facility contains conditions to making loans, representations, warranties and covenants, including financial covenants, customary for a transaction of this type. Financial covenants include (i) a ratio of total indebtedness to consolidated EBITDA not to exceed 2.50 to 1.00; (ii) minimum risk-based capital for each HMO subsidiary; and (iii) a minimum fixed charge coverage ratio of 1.75 to 1.00. The senior credit facility also contains customary events of default as well as restrictions on undertaking certain specified corporate actions including, among others, asset dispositions, acquisitions and other investments, dividends, changes in control, issuance of capital stock, fundamental corporate changes such as mergers and consolidations, incurrence of additional indebtedness, creation of liens, transactions with affiliates, and agreements as to certain subsidiary restrictions. If an event of default occurs that is not otherwise waived or cured, the lenders may terminate their obligations to make loans under the senior credit facility and the obligations of the issuing banks to issue letters of credit and may declare the loans then outstanding under the senior credit facility to be due and payable. We believe we are currently in compliance with our financial and other covenants under the senior credit facility. As of June 30, 2006, no amounts were outstanding under the senior revolving credit facility.

In connection with the recapitalization in March 2005, we entered into a senior credit facility, or the Prior Credit Facility, and also issued senior subordinated notes. The Prior Credit Facility provided for a revolving credit facility in an aggregate principal amount of up to $15.0 million. The Prior Credit Facility remained in place following the IPO although we had no outstanding indebtedness thereunder. The senior subordinated notes, issued by the company, bore interest at an annual rate of 15%, 12% of which was payable quarterly in cash and 3% of which accrued quarterly and was added to the outstanding principal amount. These amounts, together with a prepayment premium of approximately $1.1 million, were repaid with proceeds from the IPO in February 2006.

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Off-Balance Sheet Arrangements

At June 30, 2006, we did not have any off-balance sheet arrangement requiring disclosure.

Commitments and Contingencies

The following table sets forth information regarding our contractual obligations as of December 31, 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	$ 199,009	$ 26,107	$ 48,893	$ 44,415	$ 79,594
Line of credit	316	76	152	88	
Subordinated debt	73,324	4,407	9,240	9,817	49,860
Medical claims	82,645	82,645			
Operating lease obligations(1)	15,298	4,576	6,367	4,355	
Other contractual obligations	330	72	144	114	
Total	$ 370,922	$ 117,883	$ 64,796	$ 58,789	$ 129,454

(1) Includes leases for office space and equipment.

The following table sets forth information regarding our contractual obligations as of June 30, 2006:

		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**
Line of credit	$ 1,336	$ 281	$ 563	$ 492	$
Medical claims	103,827	103,827			
Operating lease obligations(1)	14,304	5,125	5,955	3,224	
Other contractual obligations	276	72	144	60	
Total	$ 119,743	$ 109,305	$ 6,662	$ 3,776	$

(1) 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 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 our IBNR. Medical expense includes claim payments, capitation payments, and prescription drug 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. Prescription drug 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.

Medical claims liability includes medical claims reported to the plans but not yet paid 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,	
	2004	2005
	(In thousands)	
Incurred but not reported (IBNR)	$ 50,432	$ 74,393
Reported claims	2,755	8,252
Total medical claims liability	$ 53,187	$ 82,645

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 IBNR. 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 we use are: in-patient facility, outpatient facility, all professional expense, and pharmacy. The lines of business are Medicare and commercial. At each of December 31, 2004 and 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 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.

Our use of the claims trend factor method considers many aspects of the managed care business. 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.

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 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 our hindsight analysis indicates this additional provision is needed to cover additional unknown adverse claims not anticipated by the standard assumptions used to produce the IBNR estimates that were incurred prior to but paid after a period end. For the years ended December 31, 2005 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 the 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, 2005 estimated claims liability and the ultimate claims paid would increase or decrease net income for the year ended December 31, 2005 by approximately $830,000.

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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, 2005 data:

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%	$ (2,349)	(3)%	$ (1,472)
2	(1,585)	(2)	(980)
1	(802)	(1)	(489)
(1)	822	1	488

(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 years ended December 31, 2004 and 2005. The 2005 presentation represents a cumulative summary for the twelve months ended December 31, 2005. See Note 12 to the consolidated financial statements for the year ended December 31, 2005 included elsewhere in this prospectus.

	Predecessor Year Ended December 31, 2004	HealthSpring, Inc. and Predecessor Combined Year Ended December 31, 2005
	(In thousands)	
Balance at beginning of period	$ 47,729	$ 53,187
Incurred related to:		
Current period	467,289	665,407
Prior period	(3,914)	(5,228)

Total incurred	463,375	660,179
Paid related to:		
Current period	415,136	582,944
Prior period	42,781	47,777
Total paid	457,917	630,721
Balance at the end of the period	$ 53,187	$ 82,645

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 each of the two years ended December 31, 2004 and 2005. During 2005, claim liability balances at

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December 31, 2004 ultimately settled for $5.2 million less than the amount originally estimated. The favorable development in 2004 and 2005 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, 2005, actual claims expense has developed favorably by 1.1% to 1.3% 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 as of December 31, 2004 and 2005.

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 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 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 monthly adjustments to our revenue based on member retroactivity, which reflect changes in the number and eligibility status of enrollees subsequent to when revenue is received. We estimate the amount of outstanding retroactivity each period and adjust premium revenue accordingly. The estimates of retroactivity adjustments are based on historic 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, 2005 and 2006, the portion of risk adjusted payments was increased to 30%, 50% and 75%, respectively, and will increase to 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 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 2004, 2005 and 2006 were 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.

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The monthly Part D payments HealthSpring receives from CMS for Part D Plans generally represents HealthSpring s bid amount for providing insurance coverage, both standard and supplemental, and is recognized as premium revenue.

Payments from CMS are based on these estimated costs. The amount of CMS payments relating to the Part D standard coverage for HealthSpring MA-PDs and PDPs is subject to adjustment, positive or negative, based upon the application of risk corridors that compare HealthSpring s prescription drug costs in its original bids to CMS to HealthSpring s actual prescription drug costs. Variances exceeding certain thresholds, or symmetric risk corridors, may result in CMS making additional payments to HealthSpring or HealthSpring s refunding to CMS a portion of the premium payments it previously received. HealthSpring estimates and recognizes an adjustment to premium revenue related to estimated risk corridor payments based upon its actual prescription drug cost for each reporting period as if the annual contract were to end at the end of each reporting period, in accordance with EITF No. 93-14, *Accounting for Multiple-Year Retrospectively Rated Insurance Contracts by Insurance Enterprises and Other Enterprises*.

Certain Part D payments from CMS represent prepayments for claims HealthSpring pays for which it assumes no risk, including reinsurance and low-income cost subsidies. HealthSpring accounts for these subsidies as funds held for the benefit of members on its balance sheet and as a financing activity in its statements of cash flows.

Goodwill and Other Intangible Assets

Goodwill represents the excess of cost 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. We have 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 its estimated future cash flows.

Recent Accounting Pronouncements

In July 2006, the Financial Accounting Standards Board issued FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes An Interpretation of FASB Statement 109*, or FIN 48. FIN 48 creates a model to address uncertainty in tax positions and clarifies the accounting for income taxes by prescribing a minimum recognition threshold which all income tax positions must achieve before being recognized in the financial statements. In addition, FIN 48 requires expanded annual disclosures, including a tabular rollforward of the unrecognized tax benefits as well as specific detail related to certain tax uncertainties. FIN 48 is effective for us on January 1, 2007. Any differences between the amounts recognized in the statements of financial position prior to the adoption of FIN 48 and the amounts reported after adoption are generally accounted for as an adjustment to retained earnings. We are currently evaluating the impact of FIN 48.

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Quantitative and Qualitative Disclosures about Market Risk

As of December 31, 2004 and 2005 and June 30, 2006, we had the following assets that may be sensitive to changes in interest rates:

Asset Class	Predecessor December 31, 2004	HealthSpring, Inc. December 31, 2005	June 30, 2006
	(In thousands)		
Investment securities, available for sale	$ 8,460	$ 8,646	$ 8,332
Investment securities, held to maturity:			
Current portion	9,413	14,313	13,228
Long-term portion	20,248	22,993	23,027
Restricted investments	5,319	5,652	6,715

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 carrying 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 2005 and June 30, 2006, 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 June 30, 2006, the fair value of our fixed income investments would decrease by approximately $430,000. Similarly, a 1% decrease in market interest rates at June 30, 2006 would result in an increase of the fair value of our investments of approximately $430,000. 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 required by the Prior Credit 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 bore interest at a fixed annual rate of 4.25% plus the applicable margin (currently 3.00%) for the period from January 1, 2006 to the date we repaid the outstanding indebtedness in February 2006. The swap did not qualify for hedge accounting. Accordingly, we recorded the change in the swap s fair market value as a component of earnings. At December 31, 2005, the fair market value of the swap was approximately $51,000. This loan facility was paid off and the swap was settled in connection with the IPO, and we do not have any borrowings outstanding under our new senior credit facility. Accordingly, the company is not currently exposed to market interest rate fluctuations on borrowings.

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BUSINESS

Overview

We believe we are one of the largest managed care organizations in the United States whose primary focus is Medicare. 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, the federal government-sponsored health insurance program for retired U.S. citizens aged 65 and older, qualifying disabled persons, and persons suffering from end-stage renal disease. Pursuant to the Medicare Advantage program (formerly known as Medicare+Choice) and the new Medicare Part D program, Medicare beneficiaries receive healthcare benefits, including prescription drugs, through a managed care health plan. Our concentration on Medicare, and the Medicare Advantage program in particular, provides us with opportunities to understand the complexities of the Medicare program, design competitive products, manage medical costs, and offer high quality healthcare benefits to Medicare beneficiaries in our local service areas. Our Medicare Advantage 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.

On January 1, 2006, we began offering prescription drug benefits in accordance with Medicare Part D to our Medicare Advantage plan members, in addition to continuing to provide other medical benefits. We also began offering prescription drug benefits on a stand-alone basis in accordance with Medicare Part D in each of our service areas. We have filed an application with CMS to expand our stand-alone PDP program on a national basis in 2007. We sometimes refer to our Medicare Advantage plans after January 1, 2006 collectively as Medicare Advantage plans and separately as MA-only for plans without prescription drug benefits and as MA-PD for plans with prescription drug benefits. We refer to our stand-alone prescription drug plans as stand-alone PDPs or PDPs. As of January 1, 2006, we began presenting our membership by distinguishing between members of our Medicare Advantage and PDP plans. As of June 30, 2006, we had over 88,100 beneficiaries enrolled in our stand-alone PDPs, substantially all of whom are auto-enrolled dual-eligible beneficiaries.

Currently, we operate Medicare Advantage plans and PDP plans 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. For the six months ended June 30, 2006 and the combined twelve-month period ended December 31, 2005, Medicare premiums accounted for approximately 87.2% and 82.4%, respectively, of our total revenue. As of June 30, 2006 our Medicare Advantage plans had over 107,600 members and our PDP plans had over 88,100 members.

Largely as a result of changes to the Medicare program pursuant to the MMA, the Congressional Budget Office expects Medicare expenditures will rise at a compounded annual growth rate of 9.3%, from approximately $333 billion in 2005 to approximately $808 billion in 2015. 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 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 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 commenced our Medicare Advantage plan 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 profitability in 2001 and have grown from servicing approximately 8,000 Medicare Advantage members in five Tennessee counties in late 2000 to serving over 107,600 Medicare Advantage members in five states as of June 30, 2006. We have grown our Medicare Advantage 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 Medicare Advantage 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 and, according to the Henry J. Kaiser Family Foundation, is approximately 43 million in 2006, and is estimated to be 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 and the new Medicare Part D, 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 beneficiaries 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 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, effective January 1, 2006, every Medicare recipient was 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

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national weighted average monthly bid for this coverage, adjusted for member demographics and risk factor payments. The beneficiary is responsible for the difference between the government subsidy and his or her plan s bid, together with the amount of his or her plan s supplemental premium (before rebate allocations), subject to the co-pays, deductibles, and late enrollment penalties, if applicable, described below. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries.

The Medicare Part D benefits are available to Medicare Advantage plan enrollees as well as Medicare fee-for-service enrollees. Medicare Advantage plan enrollees who elect to participate may pay a monthly premium for this Medicare Part D prescription drug benefit, or MA-PD, while fee-for-service beneficiaries will be able to purchase a stand-alone prescription drug plan, or PDP, from a list of CMS-approved PDPs available in their area. Our Medicare Advantage members were automatically enrolled in our MA-PD plans as of January 1, 2006 unless they chose another provider s prescription drug coverage or one of our other plan options without drug coverage. Any Medicare Advantage member enrolling in a stand-alone PDP, however, is automatically disenrolled from the Medicare Advantage plan altogether, thereby resuming traditional fee-for-service Medicare. In addition, certain dual-eligible beneficiaries are automatically enrolled with approved PDPs in their region, as described below. Under the standard Part D drug coverage for 2006, beneficiaries enrolled in a stand-alone PDP pay a $250 deductible, co-insurance payments equal to 25% of the drug costs between $250 and the initial annual coverage limit of $2,250, and all drug costs between $2,250 and $5,100, which is commonly referred to as the Part D doughnut hole. After the beneficiary has incurred $3,600 in out-of-pocket drug expenses, the MMA provides 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. As additional incentive to enroll in a Part D prescription drug plan, CMS will impose a cumulative penalty added to a beneficiary s monthly Part D plan premium in an amount equal to 1% of the applicable premium for each month between the date of a beneficiary s enrollment deadline and the beneficiary s actual enrollment. This penalty amount will be passed through the plan to the government. Each Medicare Advantage plan is required to offer a Part D drug prescription plan as part of its benefits. We currently offer MA-PD benefits and stand-alone PDPs in each of our markets.

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

Bidding Process. Although Medicare Advantage plans will continue to be paid on a capitated, or PMPM, basis, as of January 1, 2006 CMS uses a new rate calculation system for Medicare Advantage plans. The new system is based on a competitive bidding process that allows the federal government to share in any cost savings achieved by Medicare Advantage plans. In general, the statutory payment rate for each county, which is primarily based on CMS s estimated per beneficiary fee-for-service expenses, was relabeled as the benchmark amount, and local Medicare Advantage plans will annually submit bids that reflect the costs they expect to incur in providing the base

Medicare Part A and Part B benefits in their applicable service areas. If the bid is less than the benchmark for that year, Medicare will pay the plan its bid amount, risk adjusted based on its risk scores, plus a rebate equal to 75% of the amount by which the benchmark exceeds the bid, resulting in an annual adjustment in reimbursement rates. Plans will be required to use the rebate to provide beneficiaries with extra benefits, reduced cost sharing, or reduced premiums, including premiums for MA-PD and other supplemental benefits. CMS will have the right to audit the use of these proceeds. The remaining 25% of the excess amount will be retained in the statutory Medicare trust fund. If a Medicare Advantage plan s bid is greater than the benchmark, the plan will be required to charge a premium to enrollees equal to the difference between the bid amount and the benchmark, which is expected to make such plans less competitive. For 2006, the county benchmarks equal the 2005 rates increased by 4.8%, which is the national growth rate in fee-for-service expenditures.

Annual Enrollment and Lock-in. Prior to the MMA, Medicare beneficiaries were permitted to enroll in a Medicare managed care plan or change plans at any point during the year. As of January 1, 2006, Medicare beneficiaries have defined enrollment periods, similar to commercial plans, in which they can select a Medicare Advantage plan, stand-alone PDP, or traditional fee-for-service Medicare. For 2007 and subsequent years, the annual enrollment period for a PDP will be from November 15 through December 31 of each year, and enrollment in Medicare Advantage plans will occur from November 15 through March 31 of the subsequent year. Enrollment on or prior to December 31 will be effective as of January 1 of the following year and enrollment on or after January 1 and within the enrollment period will be effective as of the first day of the month following the date on which the enrollment occurred. After these defined enrollment periods end, generally only seniors turning 65 during the year, Medicare beneficiaries who permanently relocate to another service area, dual-eligible beneficiaries and others who qualify for special needs plans and employer group retirees will be permitted to enroll in or change health plans during that plan year. Eligible beneficiaries who fail to timely enroll in a Part D plan will be subject to the penalties described above if they later decide to enroll in a Part D plan. The initial enrollment period for 2006 began November 15, 2005 and continued through May 15, 2006 for a MA-PD or stand-alone PDP. In addition, beneficiaries had an open election period from January 1, 2006 through June 30, 2006 in which they could make or change an equivalent election. The annual enrollment and lock-in provisions of the MMA have been suspended in our service areas in Mississippi for 2006 as a result of Hurricane Katrina.

Our Competitive Advantages

We believe the following are our key competitive advantages:

Focus on Medicare Advantage Market. We are focused primarily on the Medicare Advantage market. We believe our focus on designing and operating Medicare Advantage health plans tailored to each of our local service areas enables us to offer superior Medicare Advantage plans and to operate those plans with what we believe to be lower MLRs. Most of our competitors offer Medicare Advantage plans that are ancillary to significantly larger commercial plans or Medicaid managed care plans. Our focus allows us to:

- build relationships with provider networks that deliver the care desired by Medicare beneficiaries in their local service areas at contractual rates that take into account Medicare reimbursement schedules;
- direct our sales and marketing efforts primarily to Medicare beneficiaries and their families, customized to the demographics of the communities in which we operate; and
- staff each of our service areas with locally-based senior managers who understand the particular dynamics influencing behavior of local Medicare beneficiaries and providers as well as political and legislative impacts on our programs.

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 in 2004, which was approximately 91% and 60%, respectively. As a result,

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we believe our growth opportunities within the Medicare Advantage market are significant. We believe our MLRs are more controllable because Medicare Advantage plans, unlike commercial plans, are only obligated to pay the amount that the hospital would have received from CMS under traditional fee-for-service Medicare based on the applicable diagnosis related group, or DRGs, with respect to out-of-area catastrophic events, such as extended chronic disease and organ transplants, and other hospitalizations and inpatient procedures.

Leading Presence in Attractive, Underpenetrated Markets. We have a significant market position in our established service areas and in many of our service areas we are the market leader in terms of the number of Medicare Advantage members. Medicare Advantage penetration is highly variable across the country as a result of various factors, including infrastructure and provider accessibility. We focus our efforts primarily on service areas we believe to be underpenetrated, providing opportunities for us to increase the membership of our plans.

The following chart summarizes for our service areas in each state in which we operate, as of April 1, 2006, the total number of MA-PD enrollees, our MA-PD membership, and our relative market position. The following chart does not include MA-only or PDP enrollees.

Market(1)	Total MA-PD Enrollees	HealthSpring, Inc. MA-PD Members(2)	Market Position (Based on Membership)
Tennessee	104,000	38,400	1
Texas	243,300	28,800	1
Alabama	82,600	24,200	2
Illinois	73,800	4,600	2
Mississippi	7,200	300	2

(1) Membership data includes only MA-PD membership in counties in which we operated or filed registration to operate as of April 1, 2006.

(2) Does not reflect CMS retroactive enrollment adjustments.

We believe our market position provides us with competitive advantages including: operating efficiencies; comprehensive provider networks; and HealthSpring name recognition with potential new members within our service areas and in areas located contiguous to or near our existing service areas.

Furthermore, we believe we are well positioned within our existing service areas to capitalize on the projected favorable Medicare Advantage enrollment trends resulting from the changes to the Medicare Advantage program implemented under the MMA.

Effective Medical Management. Our medical management efforts are designed primarily for the Medicare Advantage program. For both the six months ended June 30, 2006 and the combined twelve-month period ended December 31, 2005, our Medicare MLR (excluding our PDP plans) was 78.4%, and our Medicare MLR for each of the years ended December 31, 2003 and 2004 were 78.1% (and 79.9%, as adjusted for the year ended December 31, 2003 to reflect our Tennessee subsidiaries on an as if consolidated basis). We believe our ability to predict and manage our medical expenses is the result of the following primary factors:

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

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Provider Partnerships Our management team has extensive experience managing providers and provider networks, including independent physician associations such as RPO. We believe this experience provides us a competitive advantage in structuring our provider contracts and provider relations generally. Our provider networks include over 13,500 physicians and 200 hospitals. We seek providers who have experience in managing the Medicare population. We attempt to partner with our providers by, among other things, aligning physician interests with our interests and the interests of our members by way of incentive compensation and risk-sharing arrangements. These incentive arrangements are designed to encourage our providers to deliver a level of care that promotes member wellness, reduces avoidable catastrophic outcomes, and improves clinical and financial results. Additionally, we internally monitor and evaluate the performance of our providers on a periodic basis to ensure these relationships are successful in meeting their goals and engage our providers directly when appropriate to address performance deficiencies individually or within their networks.

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

Scalable Operating Structure. We have centralized certain functions of our health plans, including claims payment, actuarial review, health risk assessment, and benefit design for operational efficiencies and to facilitate our analytical, data-driven approach to operations. Other functions, including member services, sales and marketing, provider relations, medical management, and financial reporting and analysis, are customized for each of our local service areas. We believe this combination of centralized administrative functions and local service area focus, including localized medical management programs and on-site personnel at facility locations, gives us an advantage over competitors who have standardized and centralized many or all of these operating and member services functions. Additionally, we have designed our centralized and local administrative and information services functions to be scalable to accommodate our growth in existing or new service areas.

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

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

Our Growth Strategy

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

Attract Fee-For-Service Beneficiaries to Our Medicare Advantage Offerings. We are focused on designing health plans that are attractive to seniors as compared with traditional fee-for-service Medicare both in terms of benefits, such as general wellness, fitness, and transportation programs, and cost-savings, including zero or reduced-copays and zero or reduced premiums. Although the benefits vary across our markets, we believe an average member in one of our Medicare Advantage plans receives more benefits for less out-of-pocket cost than traditional fee-for-service Medicare. We will continue to focus our marketing efforts on educating the Medicare eligible population in our service areas about the advantage of our plan benefits, including our MA-PD benefits, over traditional fee-for-service and potentially substantial cost-savings.

Increase Membership within Existing Service Areas. We have historically operated in service areas where there have been few or no competing Medicare Advantage plans and relatively low Medicare Advantage penetration percentages. We believe that the projected rise in Medicare expenditures, coupled with the projected favorable Medicare Advantage enrollment trends, will have a corresponding positive impact on Medicare Advantage penetration in our markets. Furthermore, as a result of our market presence in our established service areas, the HealthSpring brand name recognition, our scalable operating structure and our planned marketing efforts, we believe we will be successful in gaining a significant share of these projected new enrollees within our service areas. We also intend to seek new members and increase market penetration by designing attractive and competitive products and benefits and continuing targeted marketing campaigns to increase awareness and acceptance by Medicare beneficiaries of Medicare Advantage plans.

Expand to New Service Areas Through Leverage of Existing Operations. We intend to increase our membership by expanding our operations into areas that are located contiguous to or near our existing service areas. We believe we can add additional members without incurring significant expenses by expanding into new areas located close to our existing service areas. For example, in July 2005 we commenced our enrollment efforts in two counties in Northern Mississippi located adjacent to our West Tennessee service area. Our operating and information systems platforms in each of our service areas are scalable and can be expanded to accommodate anticipated growth. As with our existing markets, we believe the projected expansion and increased acceptance of the Medicare Advantage market generally will create additional opportunities for growth in contiguous or nearby service areas.

Pursue Dual-Eligible Beneficiaries. The Kaiser Commission on Medicaid and the Uninsured estimates that in 2003, the date of the latest available published data, there were over 1.3 million dual-eligible beneficiaries in the states in which we operate (including Mississippi). Currently, CMS pays an additional premium ranging from approximately $100 to $300 PMPM for dual-eligible individuals. We believe Medicare Advantage plans are better suited than Medicaid plans to care for the dual-eligible population because Medicare Advantage plans possess the provider networks and medical management capabilities that are specifically designed for the needs of the elderly population. Many dual-eligible beneficiaries do not know they qualify for additional benefits. Since January 2005, we have been offering a special needs product in all of our markets, targeted at dual-eligible members, who pay no additional premium and make no co-payments. The change to the prescription drug benefit for dual-eligible beneficiaries should help Medicare Advantage plans, including ours, identify and attract dual-eligible beneficiaries. We expect to also benefit from the pro-rata allocation of the auto-assigned dual-eligible beneficiaries to our stand-alone PDPs within our regions.

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Expand Our Stand-Alone Prescription Drug Plan Coverage on a National Basis. Historically, we have provided a prescription drug benefit as part of our Medicare Advantage plans and began offering a prescription drug benefit as part of our Medicare Advantage plan offerings in accordance with Part D, or MA-PDs, beginning in January 2006. We also began offering a stand-alone PDP under Part D of Medicare in each of our markets as of January 1, 2006. We have filed an application with CMS to expand our stand-alone PDP program on a national basis in 2007. Although we compete with many managed care and other companies, including pharmaceutical distributors and retailers and pharmacy benefit managers, who offer stand-alone PDPs, we believe our strong presence in our markets, our medical cost management programs and expertise, and our experience in designing, marketing, and managing benefits, including prescription drug benefits, for Medicare beneficiaries will enable us to offer cost-effective, attractive, and competitive MA-PD benefits and stand-alone PDPs. There is also an opportunity for us to market our Medicare Advantage plans to Medicare beneficiaries that initially only sign up for, or dual-eligible beneficiaries that are automatically assigned to and enrolled in, our stand-alone PDP plans.

Pursue Acquisitions Opportunistically. We intend to selectively pursue acquisitions in our existing and in new service areas. Although most of our membership increases are from internal growth, we completed three acquisitions of a total of approximately 18,000 member lives to launch our entrance into Tennessee, Texas, and Alabama. We believe acquisition opportunities will increase as managed care companies with less Medicare Advantage focus or experience than us (or who are operating Medicare Advantage plans with less scale) struggle to operate their Medicare Advantage plans profitably as a result of the significant changes mandated by the MMA. In evaluating acquisition opportunities, we will generally look for the same or similar demographics and operating factors we consider important when evaluating entry into a new service area, including: service areas with large Medicare and dual-eligible populations; service areas with low Medicare Advantage penetration and few competitors; opportunities to leverage our existing operating infrastructure; high quality hospitals and physicians or groups of physicians who have favorable Medicare expenses, experience treating Medicare beneficiaries and managing costs on a risk basis or a willingness to use our management services; and available, experienced senior managers, with demonstrated experience in managing provider contracts on a risk basis.

Products and Services

We offer Medicare health plans, including MA-only, MA-PD, and stand-alone PDP plans, in each of our markets. Our Medicare Advantage plans cover Medicare eligible members with benefits that are at least comparable to those offered under traditional Medicare fee-for-service plans. Through our plans, we have the flexibility to offer benefits not covered under traditional fee-for-service Medicare. Our plans are designed to be attractive to seniors and offer a broad range of benefits that vary across our markets and service areas but may include, for example, mental health benefits, dental, vision and hearing benefits, transportation services, preventive health services such as health and fitness programs, routine physicals, various health screenings, immunizations, chiropractic services, and mammograms. Most of our Medicare Advantage members pay no monthly premium in addition to the premium we receive from Medicare but are subject in some cases to co-payments and deductibles, depending upon the market and benefit. Our Medicare Advantage members are required to use a primary care physician within our network of providers, except in limited cases, including emergencies, and generally must receive referrals from their primary care physician in order to see a specialist or other ancillary provider. In addition to our typical Medicare Advantage benefits, we offer a special needs zero premium, zero co-payment plan to dual-eligible individuals in each of our markets.

The amount of premiums we receive for each Medicare member is established by contract, although it varies according to various demographic factors, including the member s geographic location, age, and gender, and is further adjusted based on our plans average risk scores. In addition to the premiums payable to us, our contracts with CMS regulate, among other matters, benefits

provided, quality assurance procedures, and marketing and advertising for our Medicare Advantage and PDP products.

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

- commercial HMO plans in Alabama and Tennessee;
- PPO network rental, which allows third party administrators to use our provider network for an access fee, in Tennessee;
- exclusive provider organization, or EPO, products for self-insured employers in Tennessee that provide access to our provider networks at negotiated rates; and
- administrative services only, or ASO, products for self-insured employers in Tennessee.

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

Our Health Plans

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

- negotiation, monitoring, and quality assurance of contracts with third party healthcare providers;
- medical management, credentialing, marketing, and product promotion;
- support services and administration;
- personnel recruiting and retention;
- financial services; and
- claims processing and other general business office services.

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The following table summarizes our Medicare Advantage, stand-alone PDP, and commercial plan membership as of the dates indicated.

	December 31,			June 30,	
	2003	2004	2005	2005	2006
Medicare Advantage Membership(1)					
Tennessee	25,772	29,862	42,509	35,720	44,814
Texas	15,637	21,221	29,706	25,348	32,225
Alabama	6,490	12,709	24,531	16,014	24,669
Illinois(2)			4,166	1,743	5,518
Mississippi(3)			369		425
Total	47,899	63,792	101,281	78,825	107,651
Medicare Stand-Alone PDP Membership					88,139
Commercial Membership(4)					
Tennessee	32,668	32,139	29,859	29,018	28,810
Alabama	21,612	16,241	11,910	12,379	9,303
Total	54,280	48,380	41,769	41,397	38,113(5)

(1) Includes MA-only and MA-PD membership.
(2) We commenced operations in Illinois in December 2004.
(3) We commenced enrollment efforts in Mississippi effective July 1, 2005.
(4) 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.
(5) We expect a decrease of at least 10,000 commercial members beginning January 1, 2007 as a result of the discontinuation of coverage with two large employers in Tennessee. We expect a decrease of 5,000 commercial members effective October 1, 2006 as a result of the discontinuation of coverage with a large employer in Alabama and expect Alabama commercial membership at December 31, 2006 to be under 3,000.

Tennessee

We began operations in Tennessee in September 2000 when we purchased a 50% interest in an unprofitable HMO in the Nashville, Tennessee area that offered commercial and Medicare products. When we purchased the plan, it had approximately 8,000 Medicare Advantage members in five counties and 22,000 commercial members in 27 counties. We purchased an additional 35% interest in the HMO in 2003 and purchased the remaining 15% in March 2005 in connection with the recapitalization.

As of June 30, 2006, our Tennessee HMO, known as HealthSpring of Tennessee, had approximately 73,600 members in 27 counties, including approximately 44,800 Medicare Advantage members, and 28,800 commercial members. In addition, through Signature Health Alliance, our wholly-owned PPO network subsidiary, we provided repricing and

access to our provider networks for approximately 89,000 members as of June 30, 2006, throughout the 20-county area of Middle Tennessee. As of January 2006, there were approximately 924,000 Medicare beneficiaries in the State of Tennessee. Our Tennessee market is primarily divided into three major service areas including Middle Tennessee, the three-county greater Memphis area, and the four-county greater Chattanooga area.

Based upon the number of members, we believe we operate the largest Medicare Advantage health plan in the State of Tennessee. We believe there are currently six competing Medicare Advantage plans in our service areas in Tennessee and that we held the leading market position as of April 2006, based on membership, in these areas. Our competitors in these service areas are Windsor Medicare Extra, Humana, Inc., Cariten Healthcare, UnitedHealth Group, Blue Cross Blue Shield and Alexian Brothers.

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Texas

We began operations in Texas in November 2000 as an independent physician association management company. We began operating an HMO in Texas in November 2002 when we acquired approximately 7,800 Medicare lives from a managed care plan in state receivership.

As of June 30, 2006, our Texas HMO had approximately 32,200 Medicare Advantage members in 20 counties in Southeast Texas, Northeast Texas, and the Rio Grande Valley. Our Texas market is primarily divided into three major service areas, including the 14-county greater Houston area, the four-county Northeast Texas area, and a two-county Rio Grande Valley area. As of January 2006, there were approximately 2.5 million Medicare beneficiaries in the State of Texas. In January 2007, we intend to expand our operations into five additional counties.

We believe we operate the largest Medicare Advantage health plan in our service areas in the State of Texas. We believe there are currently five competing Medicare Advantage plans in our service areas in Texas and that we held the leading market position as of April 2006, based on membership. Our competitors in these service areas are Humana, Inc., Universal American Financial Corp., United Health Group, AMERIGROUP and Valley Baptist Health Plan.

Alabama

We began operations in Alabama in November 2002 when we purchased an HMO with approximately 23,000 commercial members and approximately 2,800 Medicare members in two counties. Our Alabama HMO, known as HealthSpring of Alabama, was profitable during the first year that we operated the health plan, and from 2002 to 2004 we increased the revenue of this HMO by over 76%.

As of June 30, 2006, HealthSpring of Alabama served over 34,000 members, including approximately 24,700 Medicare Advantage members and 9,300 commercial members in 42 counties. As of January 2006, there were approximately 757,000 Medicare beneficiaries in the State of Alabama. As we generally operate statewide, we do not have distinct primary service areas in Alabama.

We discontinued offering commercial benefits to individuals and small group employers in Alabama effective May 31, 2006. Prior to May 31, 2006, small employer groups enrolled in our commercial plans could elect to continue participating in our plans through May 31, 2007. As of June 30, 2006, there were 1,558 commercial members participating in our individual and small employer group plans in Alabama. Pursuant to Alabama and federal law, as a result of our decision to exit the individual and small group commercial markets, we may not reenter the individual and small group employer commercial markets in Alabama until November 30, 2010.

We believe we operate the fastest growing Medicare Advantage plan in the State of Alabama. We believe there are currently four principal competing Medicare Advantage plans in our service areas in the State of Alabama, and that our market position as of April 2006, based on membership, was second. Our principal competitors in these service areas are UnitedHealth Group, Viva Health, a member of the University of Alabama at Birmingham Health System, Blue Cross Blue Shield and Humana, Inc.

Illinois

We began operations in Illinois in December 2004 and, as of June 30, 2006, our Medicare Advantage plan in Illinois, known as HealthSpring of Illinois, served approximately 5,500 beneficiaries in eight counties in the Chicago area. HealthSpring of Illinois is one of four managed care companies currently offering competing Medicare Advantage

plans that operate in the greater Chicago metropolitan area, and we believe our primary competitor is Humana, Inc.

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As of January 2006, there were approximately 1.7 million Medicare beneficiaries in the State of Illinois. Prior to the impact of the budget restrictions and other changes to the Medicare program following the BBA, there were approximately 150,000 Medicare beneficiaries in the Chicago metropolitan area enrolled in Medicare managed care plans. We believe that our entry into this market, together with the changes in Medicare Advantage benefits prompted by MMA, will result in renewed interest and increased enrollment in Medicare Advantage plans in the Chicago area generally.

Mississippi

We commenced our enrollment efforts in July 2005 for our Medicare Advantage plan, known as HealthSpring of Mississippi, in two counties in northern Mississippi located near Memphis, Tennessee. We entered these service areas consistent with our growth strategy to leverage existing operations to expand to new service areas located near or contiguous to our existing service areas. We are licensed and intend to expand our operations in our Mississippi market to include six counties in southern Mississippi located near Mobile, Alabama. We temporarily delayed our expansion efforts in Mississippi following Hurricane Katrina. The annual enrollment and lock-in provisions of the MMA have been suspended in our service areas in Mississippi as a result of Hurricane Katrina.

As of January 2006, there were approximately 455,000 Medicare beneficiaries in the State of Mississippi, including approximately 88,000 Medicare beneficiaries in our service areas in Mississippi. Currently, we believe Humana, Inc. is the only other managed care company offering a competing Medicare Advantage plan in the State of Mississippi.

Medical Health Services Management and Provider Networks

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

Our disease management programs are focused on prevention and care and are designed to support the coordination of healthcare intervention, physician/patient relationships and plans of care, preventive care and patient empowerment with the goal of improving the quality of patient care and controlling related costs. Our disease management programs are focused primarily on high-risk care management and the treatment of our chronically ill members, which generally are the least healthy of our member population and often account for a significant portion of costs of managed care plans. These programs are designed to efficiently treat patients with specific high risk or chronic conditions such as coronary artery disease, congestive heart failure, prenatal and premature infant care, end stage renal disease, diabetes, asthma related conditions, and certain other conditions. In addition to internal disease management efforts, we have partnered with outsourced disease management companies.

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

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

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

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

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

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

In some markets, we have entered into exclusive arrangements with provider organizations or networks. For example, in Texas we have partnered with RPO, a large group of 13 independent physician associations with over 1,100 physicians, including approximately 450 primary care physicians, or PCPs, and approximately 28,300 enrolled members located primarily in seven counties in the State of Texas. In the RPO service area, RPO exclusively contracts in the Medicare Advantage market with our Texas HMO, Texas HealthSpring, LLC.

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

We are also planning to open later in 2006 our first clinic dedicated to our Medicare plan members, partnering with the same medical group in Tennessee that experienced the encouraging pay-for-quality results discussed above. The clinic will be designed with the Medicare member in mind, with amenities designed to minimize any barrier to patient access such as single floors (no elevators or stairs); adjacent parking or valet service and, in some cases pick-up and return services; open reception areas; on-site nutritionists, dieticians, and nurse educators; wide corridors and doors;

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handicapped-accessible facilities; and electronic medical records. We believe clinics have the potential to improve member satisfaction, service levels, and clinical outcomes and provide for a more satisfying and cost-efficient manner for the physician to deliver care. We also believe clinics will give us an advantage over our competitors, creating a more attractive network for our members.

The following table shows the number of physicians, specialists, and other providers participating in our networks as of August 31, 2006:

Market	Primary Care Physicians	Specialists	Hospitals	Ancillary Providers
Tennessee	1,439	3,970	57	398
Texas	827	1,324	50	295
Alabama	1,001	2,636	68	195
Illinois	452	1,441	24	195
Mississippi	81	365	3	9
Total	3,800	9,736	202	1,092

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

We strive to be the preferred Medicare Advantage partner for providers in each market we serve. In addition to risk-sharing and other incentive-based financial arrangements, we seek to promote a provider-friendly relationship by paying claims promptly, providing periodic performance and efficiency evaluations, providing convenient, web-based access to eligibility data and other information, and encouraging provider input on plan benefits. We also emphasize quality assurance and compliance by periodically reviewing our networks and providers. By fostering a collaborative, interactive relationship with our providers, we are better able to gather data relevant to improving the level of preventive healthcare available under our plans, monitor the utilization of medical treatment and the accuracy of patient encounter data, risk coding and the risk scores of our plans, and otherwise ensure our contracted providers are providing high-quality and timely medical care.

Provider Arrangements and Payment Methods

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

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

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

capitation, based on a PMPM payment, where physicians generally assume the professional risk, or where a hospital or health system generally assumes the institutional or professional risk or both; and

risk-sharing arrangements, typically with a physician group, where we advance, on a PMPM basis, amounts designed to cover the anticipated professional risk and then adjust payments,

on a monthly basis, between us and the physician group based on actual experience measured against pre-determined sharing ratios.

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

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

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

Sales and Marketing Programs

As of August 31, 2006, our sales force consisted of approximately 480 third party agents and 70 internal licensed sales employees (including in-house telemarketing personnel). Our third party agents are compensated on a commission basis. Medicare Advantage enrollment is generally a decision made individually by the member. Accordingly, our sales agents and representatives focus their efforts on in-person contacts with potential enrollees. In addition to traditional marketing methods including direct mail, telemarketing, radio, internet and other mass media, and cooperative advertising with participating hospitals and medical groups to generate leads, we also conduct community outreach programs in churches and community centers and in coordination with government agencies. We regularly participate in local community health fairs and events, and seek to become involved with local senior citizen organizations to promote our products and the benefits of preventive care. Our sales and marketing programs are tailored to each of our local service areas and are designed with the goal of educating, attracting, and retaining members and providers. In addition, we seek to create ethnically and culturally competent marketing programs where appropriate that reflect the diversity of the areas that we serve.

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

Prior to 2006, Medicare beneficiaries could enroll in or change health plans at any time during the year. As of January 1, 2006, Medicare beneficiaries have a limited annual enrollment period during which they can choose

between a Medicare Advantage plan and traditional fee-for-service Medicare. After this annual enrollment period ends, generally only seniors turning 65 during the year,

dual-eligible beneficiaries and others who qualify for special needs plans, Medicare beneficiaries permanently relocating to another service area, and employer group retirees will be permitted to enroll in or change health plans. For 2007 and future years, the annual enrollment period will be from November 15 through December 31 each year for stand-alone PDPs and through March 31 of the following year for Medicare Advantage plans. Although our experience to date with the prospect of limited enrollment has not resulted in significant changes to our sales and marketing efforts, we have not fully determined whether the impact of limited enrollment will adversely affect our sales and marketing efforts or our business as a whole.

Quality Assurance

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

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

Competition

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

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

- additional premiums, if any, payable by the beneficiary;
- benefits offered;
- location and choice of healthcare providers;
- quality of customer service and administrative efficiency;
- reputation for quality care;
- financial stability of the plan; and

accreditation results.

A number of these competitive elements are partially dependent upon and can be positively affected by financial resources available to a health plan. We face competition from other managed

care companies that have greater financial and other resources, larger enrollments, broader ranges of products and benefits, broader geographical coverage, more established reputations in the national market and in our markets, greater market share, larger contracting scale and lower costs. Superior benefit design, provider network and community perception may also provide a distinct competitive advantage. If a competing plan is able to gain a competitive advantage over us in our markets, it may negatively impact our enrollment and profitability.

Regulation

Overview

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

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

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

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

Federal Regulation

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

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

Additionally, the marketing activities of Medicare Advantage plans are strictly regulated by CMS. For example, CMS has oversight over all, and in some cases has imposed advance approval

requirements with respect to, marketing materials used by our Medicare Advantage plans, and our sales activities are limited to activities such as conveying information regarding the benefits of preventive care, describing the operations of managed care plans, and providing information about eligibility requirements. Federal law precludes states from imposing additional marketing restrictions on Medicare Advantage plans. States, however, remain free to regulate, and typically do regulate, the marketing activities of plans that enroll commercial beneficiaries.

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

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

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

Federal False Claims Act. We are subject to a number of laws that regulate the presentation of false claims or the submission of false information to the federal government. For example, the federal False Claims Act provides, in part, that the federal government may bring a lawsuit against any person or entity whom it believes has knowingly presented, or caused to be presented, a false or fraudulent request for payment from the federal government, or who has made a false statement or used a false record to get a claim approved. The federal government has taken the position that claims presented in violation of the federal Anti-Kickback Statute may be considered a violation of the federal False Claims Act. Violations of the False Claims Act are punishable by treble damages and penalties of up to $11,000 per false claim. In addition to suits filed by the government, a special provision under the False Claims Act allows a private individual (e.g., a whistleblower such as a disgruntled former employee, competitor or patient) to bring an action under the False Claims Act on behalf of the government alleging that an entity has defrauded the federal government and permits the whistleblower to share in any settlement or judgment that may result from that lawsuit. Although we strive to operate our business in compliance with all applicable rules and regulations, we may be subject to investigations and lawsuits under the False Claims Act that may be initiated either by the

government or a whistleblower. It is not possible to predict the impact such actions may have on our business.

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

For example, the Department of Health and Human Services, or DHHS, issued a final rule that establishes the standard data content and format for the electronic submission of claims and other administrative health transactions. Although we believe our operations are compliant with the electronic data standards established by the final rule, to the extent that we submit to Medicare electronic healthcare claims and payment transactions that are deemed not to be in compliance with these standards, payments to us may be delayed or denied. Additionally, DHHS has issued a final privacy rule and final security standards that apply to individually identifiable health information. The primary purposes of the privacy rule are to protect and enhance the rights of consumers by providing them access to their health information and controlling the inappropriate use of that information, and to improve the efficiency and effectiveness of healthcare delivery by creating a national framework for health privacy protection that builds on efforts by states, health systems, individual organizations, and individuals. The final rule for security standards establishes minimum standards for the security of individually identifiable health information that is transmitted or maintained electronically. We will conduct our operations in an attempt to comply with the requirements of the privacy rule and the security standards. There can be no assurance, however, that upon review regulatory authorities will find that we are in compliance with these requirements.

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

Employee Retirement Income Security Act of 1974. The provision of services to certain employee health benefit plans is subject to the Employee Retirement Income Security Act of 1974, or ERISA. ERISA regulates certain aspects of the relationships between plans and employers who maintain employee benefit plans subject to ERISA. Some of our administrative services and other activities may also be subject to regulation under ERISA.

The U.S. Department of Labor adopted federal regulations that establish claims procedures for employee benefit plans under ERISA. The regulations shorten the time allowed for health and disability plans to respond to claims and appeals, establish requirements for plan responses to appeals and expand required disclosures to participants and beneficiaries. These regulations have not had a material adverse effect on our business.

State Regulation

Though generally governed by federal law, each of our HMO subsidiaries is licensed in the market in which it operates and is subject to the rules, regulations, and oversight by the applicable state department of insurance in the areas of licensing and solvency. Our HMO subsidiaries file reports with these state agencies describing their capital structure, ownership, financial condition, certain inter-company transactions and business operations. Our HMO subsidiaries are also generally required to demonstrate among other things, that we have an adequate provider network, that our

systems are capable of processing provider s claims in a timely fashion and of collecting and analyzing the information needed to manage their business. State regulations also require the prior approval or notice of acquisitions or similar transactions involving an HMO, and of certain transactions between an HMO and its parent or affiliated entities or persons. Generally, our HMOs are limited in their ability to pay dividends to their stockholders.

Our HMO subsidiaries are required to maintain minimum levels of statutory capital. The minimum statutory capital requirements differ by state and are generally based on a percentage of annualized premium revenue, a percentage of annualized healthcare costs or risk-based capital, or RBC, requirements. The RBC requirements are based on guidelines established by the National Association of Insurance Commissioners, or NAIC and are administered by the states. If adopted, the RBC requirements may be modified as each state legislature deems appropriate for that state. Currently, only our Texas HMO subsidiary is subject to RBC requirements and our other HMO subsidiaries are subject to other minimum statutory capital requirements mandated by the states in which they are licensed. These requirements assess the capital adequacy of an HMO subsidiary based upon investment asset risks, insurance risks, interest rate risks and other risks associated with its business to determine the amount of statutory capital believed to be required to support the HMO s business. If the HMO s statutory capital level falls below certain required capital levels, the HMO may be required to submit a capital corrective plan to the state department of insurance, and at certain levels may be subjected to regulatory orders, including regulatory control through rehabilitation or liquidation proceedings.

Managed Care Legislative Proposals

Proposals are regularly introduced in the U.S. Congress and various state legislatures relating to managed healthcare reform. On the federal level, while the MMA recently overhauled the Medicare program, it is possible that significant managed healthcare reform may be enacted in the future. At this time, it is unclear as to when any federal legislation might be enacted or the timing or content of any new federal legislation, and we cannot predict the effect on our operations of any pending or other legislation that may be adopted in the future. The provisions of legislation that may be introduced or adopted at the state level cannot be accurately and completely predicted at this time either, and we therefore cannot predict the effect of proposed or future legislation on our operations.

Technology

We have developed and implemented integrated and reliable information technology systems that we believe have been critical to our success. Our systems collect and process information centrally and support our core administrative functi