METROPOLITAN HEALTH NETWORKS INC
Form 10-K
March 02, 2011

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM 10-K

x ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2010

OR

o TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from _____ to _____

Commission file number: 0-28456

METROPOLITAN HEALTH NETWORKS, INC.
(Exact name of registrant as specified in its charter)

Florida	65-0635748
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
250 South Australian Avenue, Suite 400 West Palm Beach, Fl. (Address of principal executive offices)	33401 (Zip Code)

(561) 805-8500
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock, $.001 par value per share	NYSE Amex

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

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

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

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

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. o

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See definitions of “large accelerated filer” “accelerated filer” and “smaller reporting company”, in Rule 12b-2 of the Exchange Act.

Large accelerated filer o	Smaller reporting company o	Accelerated filer x	Non-accelerated filer o

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

As of June 30, 2010, the aggregate market value of the registrant’s common stock held by non-affiliates of the registrant was $91,964,322 based on the closing sale price as reported on the NYSE Amex. This calculation has been performed under the assumption that all directors, officers and stockholders who own more than 10% of our outstanding voting securities are affiliates of the Company.

Indicate the number of shares outstanding of each of the issuer’s classes of common stock, as of the latest practicable date.

Class	Outstanding at February 18, 2011
Common Stock, $.001 par value per share	40,750,000 shares

DOCUMENTS INCORPORATED BY REFERENCE

The information required by Part III of this report, to the extent not set forth herein, is incorporated by reference from the registrant’s definitive proxy statement relating to the 2011 annual meeting of shareholders, which definitive proxy statement will be filed with the Securities and Exchange Commission within 120 days after the end of the fiscal year to which this report relates.

METROPOLITAN HEALTH NETWORKS, INC.

FORM 10-K
For the Year Ended
December 31, 2010

TABLE OF CONTENTS

ITEM		Page No.
	PART I	
1	Business	5
1A	Risk Factors	20
1B	Unresolved Staff Comments	30
2	Properties	30
3	Legal Proceedings	30
	PART II	
5	Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities	31
6	Selected Financial Data	33
7	Management's Discussion and Analysis of Financial Conditions and Results of Operations	34
7A	Quantitative and Qualitative Disclosures about Market Risk	46
8	Financial Statements and Supplementary Data	47
9	Changes in and Disagreements with Accountants on Accounting and Financial Disclosure	47
9A	Controls and Procedures	47
	PART III	
10	Directors, Executive Officers and Corporate Governance	49
11	Executive Compensation	49
12	Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters	49
13	Certain Relationships and Related Transactions and Director Independence	49
14	Principal Accounting Fees and Services	50
	PART IV	
15	Exhibits, Financial Statement Schedules	50
	Exhibits Index	51
	Signatures	54

GENERAL

Unless otherwise indicated or the context otherwise requires, all references in this Form 10-K to "we," "us," "our," "Metropolitan" or the "Company" refer to Metropolitan Health Networks, Inc. and its consolidated subsidiaries unless the context suggests otherwise.

CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

Some of the discussion under the captions "Risk Factors," "Management's Discussion and Analysis of Financial Condition and Results of Operations," "Business" and elsewhere in this Form 10-K may include certain "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934, including, without limitation, statements with respect to anticipated future operations and financial performance, growth and acquisition opportunities and other similar forecasts and statements of expectation. We intend such statements to be covered by the safe harbor provisions for forward looking statements created thereby. These statements involve known and unknown risks and uncertainties, such as our plans, objectives, expectations and intentions, and other factors that may cause us, or our industry's actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by the forward-looking statements. Many of these factors are listed in Item 1A"Risk Factors" and elsewhere in this Form 10-K.

In some cases, you can identify forward-looking statements by statements that include the words "estimate," "project," "anticipate," "expect," "intend," "may," "should," "believe," "seek" or other similar expressions.

Specifically, this report contains forward-looking statements, including statements regarding the following topics:

- the ability of our provider services network (the "PSN") to renew those Humana Agreements (as defined below) with one-year renewable terms and maintain all of the Humana Agreements on favorable terms;
- the factors that we believe may mitigate the impact of anticipated premium reductions;
- our ability to make reasonable estimates of Medicare retroactive capitation fee adjustments; and
- our ability to adequately predict and control medical expenses and to make reasonable estimates and maintain adequate accruals for incurred but not reported ("IBNR") claims.

The forward-looking statements reflect our current view about future events and are subject to risks, uncertainties and assumptions. We wish to caution readers that certain important factors may have affected and could in the future affect our actual results and could cause actual results to differ significantly from those expressed in any forward-looking statement. The following important factors could prevent us from achieving our goals and cause the assumptions underlying the forward-looking statements and the actual results to differ materially from those expressed in or implied by those forward-looking statements:

- reductions in government funding of the Medicare program and changes in the political environment that may affect public policy and have an adverse impact on the demand for our services;
- the loss of or a material negative price amendment to significant contracts;
- disruptions in the PSN's or Humana's healthcare provider networks;

- failure to receive accurate and timely revenue, claim, membership and other information from Humana;
- future legislation and changes in governmental regulations;
- increased operating costs;

- reductions in premium payments to Medicare Advantage plans;
- the impact of Medicare Risk Adjustments on payments we receive from Humana;
- the impact of the Medicare prescription drug plan on our operations;
- general economic and business conditions;
- increased competition;
- the relative health of our customers;
- changes in estimates and judgments associated with our critical accounting policies;
- federal and state investigations;
- our ability to successfully recruit and retain key management personnel and qualified medical professionals; and
- impairment charges that could be required in future periods.

We undertake no obligation to revise or publicly release the results of any revision to any forward-looking statements.

PART I

ITEM 1 DESCRIPTION OF BUSINESS

Metropolitan Health Networks, Inc. ("Metropolitan") is a for profit corporation incorporated under the laws of Florida. We operate a provider services network (the "PSN"), through which we provide and arrange for medical care primarily to Medicare Advantage beneficiaries in the State of Florida who have enrolled in health plans primarily operated by Humana, Inc. ("Humana"), or its subsidiaries, one of the largest participants in the Medicare Advantage program in the United States. We operate the PSN through our wholly-owned subsidiary, Metcare of Florida, Inc. As of December 31, 2010, the PSN operated in 16 Florida counties and provided healthcare benefits to approximately 34,800 Medicare Advantage beneficiaries and primary care physician services to several thousand non-Humana Participating Customers for which we are paid on a fee-for-service basis.

Medicare is the national, federally-administered health insurance program that covers the cost of hospitalization, medical care, and some related health services for U.S. citizens aged 65 and older, qualifying disabled persons and persons suffering from end-staged renal disease. Substantially all of our revenue in 2010 and 2009 was generated by providing services to Medicare beneficiaries through arrangements that require us to assume responsibility to provide and/or manage the care for our customers' medical needs in exchange for a monthly fee, also known as a capitation fee or capitation arrangement. In 2008, substantially all of our revenue was earned through our contracts with Humana and from premiums paid to our health maintenance organization (the "HMO") by the Centers for Medicare & Medicaid Services ("CMS"), agency of the United States Department of Health and Human Services ("HHS") which administers the Medicare program. To mitigate our exposure to high cost medical claims, we have reinsurance arrangements that provide for the reimbursement of certain customer medical expenses. See "Insurance."

Our concentration on Medicare customers provides us the opportunity to focus our efforts on understanding the specific needs of Medicare beneficiaries in our local service areas. Our management team has extensive experience developing and managing providers and provider networks.

Until the end of August 2008, we also operated our HMO, which provided healthcare benefits to Medicare Advantage beneficiaries in 13 Florida counties. The HMO was sold to Humana Medical Plan, Inc. ("Humana Plan, Inc.") on August 29, 2008.

Our corporate headquarters are located at 250 South Australian Avenue, Suite 400, West Palm Beach, Florida 33401 and our telephone number is (561) 805-8500. In March 2011, we expect to move to a new corporate headquarters location at 777 Yamato Road, Suite 510, Boca Raton, Florida 33431. Our corporate website is www.metcare.com. Information contained on our website is not incorporated by reference into this report and we do not intend the information on or linked to our website to constitute part of this report. We make available our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and any amendments to those reports on our website, free of charge, to individuals interested in acquiring such reports. The reports can be accessed at our website as soon as reasonably practicable after they are electronically filed with, or furnished to, the Securities and Exchange Commission (the "SEC"). The public may read and copy these materials at the SEC's public reference room at 100 F Street, N.E., Washington D.C. 20549 or on their website at http://www.sec.gov. Questions regarding the operation of the public reference room may be directed to the SEC at 1-800-732-0330.

Provider Services Network

The PSN currently operates under three network agreements with Humana (collectively, the "Humana Agreements") pursuant to which the PSN provides, on a non-exclusive basis, healthcare services to Medicare beneficiaries in certain Florida counties who have elected to receive benefits under a Humana Medicare Advantage HMO Plan ("Humana Plan

Customers"). We entered into the most recent of the Humana Agreements, a five-year independent practice association participation agreement (the "IPA Agreement"), in connection with the sale of the HMO. The IPA Agreement covers the 13 Florida counties where the HMO operated at the time of the sale.

At December 31, 2010, we have customers in 16 of the 30 Florida counties covered under the Humana Agreements.

Humana directly contracts with CMS and is paid a monthly premium payment for each Humana Plan Customer. Among other factors, the monthly premium varies by customer, county, age and severity of health status. For each Humana Plan Customer who selects one of the PSN physicians as his or her primary care physician (a "Humana Participating Customer") we provide or arrange for the provision of covered medical services. In return the PSN receives from Humana a capitation fee for each Humana Participating Customer established pursuant to the Humana Agreements. The amount we receive from Humana represents a substantial percentage of the monthly premiums received by Humana from CMS with respect to Humana Participating Customers.

Our PSN assumes full responsibility for the provision or management of all necessary medical care for each of the approximately 34,400 Humana Participating Customers covered by the Humana Agreements, even for services we do not provide directly. For the approximately 5,700 Humana Participating Customers covered under one of our network agreements, our PSN and Humana share in the cost of inpatient hospital services and the PSN is responsible for the full cost of all other medical care provided to the Humana Participating Customers. For the remaining 28,700 Humana Participating Customers covered under our other two network agreements, our PSN is responsible for the cost of all medical care provided. To the extent the costs of providing such medical care are less than the related fees received from Humana; our PSN generates a gross profit. Conversely, if medical expenses exceed the fees received from Humana, our PSN experiences a deficit in gross profit.

We have built our PSN by contracting with independent primary care physician practices (each, an "IPA") for their services and acquiring and operating our own physician practices. Through the Humana Agreements, we have established referral relationships with a large number of specialist physicians, ancillary service providers, pharmacies and hospitals throughout the counties covered by the Humana Agreements.

Effective August 1, 2007, our PSN entered into a network agreement (the "CarePlus Agreement") with CarePlus Health Plans, Inc. ("CarePlus"). On August 1, 2008, the CarePlus Agreement was expanded to cover 13 additional counties. CarePlus is a Medicare Advantage HMO in Florida and is a wholly-owned subsidiary of Humana. Pursuant to the CarePlus Agreement, the PSN manages, on a non-exclusive basis, healthcare services for Medicare beneficiaries in certain Florida counties who have elected to receive benefits through CarePlus' Medicare Advantage plans (each, a "CarePlus Plan Customer") and who have selected one of the PSN physicians as their primary care physician (each a "CarePlus Participating Customer"). At December 31, 2010, we operated in 10 of the 22 Florida counties covered by the CarePlus Agreement.

Like Humana, CarePlus directly contracts with CMS and is paid a monthly premium payment for each CarePlus Plan Customer, which premium varies by, among other things, customer, county, age and severity of health status. Pursuant to the CarePlus Agreement, the PSN provides or arranges for the provision of covered medical services to CarePlus Participating Customers. From the establishment of the CarePlus Agreement until January 31, 2010, the PSN received a monthly network administration fee for each CarePlus Participating Customer. Effective February 1, 2010, the PSN began to receive a capitation fee from CarePlus and assumed full responsibility for the cost of all medical services provided to each CarePlus Participating Customer. The capitation fee represents a substantial portion of the monthly premium received by CarePlus from CMS with respect to CarePlus Participating Customers.

In nine of the counties covered by the CarePlus Agreement the PSN physicians who provide services to the Humana Participating Customers are not allowed to provide services to CarePlus Participating Customers. In these counties, the PSN must (i) locate and contract with new independent primary care physician practices and/or (ii) acquire or establish and operate its own physician practices to service the CarePlus Participating Customers. In the remaining counties covered by the CarePlus Agreement, the PSN is allowed to use the PSN physicians who provide services to the Humana Participating Customers.

The CarePlus Agreement covered approximately 370 CarePlus Participating Customers at December 31, 2010.

Government Regulation

The Medicare Program and Medicare Managed Care

Medicare

Medicare is a federal program that provides persons age 65 and over, qualifying disabled persons and persons suffering from end-stage renal disease with certain hospital and medical insurance benefits. The Medicare program 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 paying 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, which is usually withheld from their Social Security checks. Medicare Part B generally pays 80% of the cost of services and beneficiaries pay the remaining 20% after the beneficiary has satisfied a deductible. To fill the gaps in traditional fee-for-service Medicare coverage, individuals may 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 accepting Medicare payments 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." Subject to limited exceptions, Medicare fee-for-service does not cover transportation, eyeglasses, hearing aids, and certain preventive services, such as annual physicals and wellness visits. However, the Medicare Improvements for Patients and Providers Act ("MIPPA") permits the Secretary of the Department of HHS to extend fee-for-service coverage to certain additional preventive services that are reasonable and necessary for the prevention or early detection of an illness or disability.

Medicare Advantage

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. Pursuant to Medicare Part C and 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 monthly per customer premium payment from CMS.

Participation of private health plans, such as Humana, in the Medicare Advantage Program under full risk contracts began in the 1980's and grew to 6.9 million customers in 1999. According to information provided by the Henry J. Kaiser Family Foundation, after a drop to 5.3 million customers in 2003, the number of enrollees in Medicare Advantage plans in the United States has increased to 11.0 million in 2010.

The Medicare Advantage program provides a comprehensive array of health insurance benefits, including wellness programs, to Medicare eligible persons under HMO, Preferred Provider Organizations ("PPO"), and Private Fee-For-Service ("PFFS") plans in exchange for contractual payments received from CMS, usually a per customer per month payment. Substantially all of our customers are enrolled in a Medicare Advantage HMO plan. Under a Medicare Advantage HMO plan, the beneficiary receives benefits in excess of traditional Medicare, typically including reduced cost sharing, enhanced prescription drug benefits, eye exams, hearing aids and routine physical exams, care coordination, data analysis techniques to help identify customer needs, complex case management, tools to guide customers in their healthcare decisions, disease management programs, wellness and prevention programs, and in some instances a reduced monthly Part B premium. Most Medicare Advantage plans offer the prescription drug benefit under Part D as part of the basic plan, subject to cost sharing and other limitations. Medicare Advantage plans may charge beneficiaries monthly premiums and other co-payments for Medicare-covered services or for certain extra benefits.

Medicare Advantage HMO plans may eliminate or reduce coinsurance or the level of deductibles on many other medical services when customers seek care from participating in-network providers or in emergency situations. Except in emergency situations, HMO plans provide no out-of-network benefits. While out-of-pocket costs for the Medicare beneficiary enrolled in a Medicare Advantage plan may be lower than under the traditional fee-for-service Medicare program, customers are generally required to use only the services and provider networks offered by the customer's Medicare Advantage plan.

CMS uses monthly rates per person for each county to determine the monthly per customer payments made to health benefit plans. These rates are adjusted under CMS's risk-adjustment model which uses health status indicators, or risk scores, to improve the adequacy of payment. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 ("BBA") and the Benefits and Improvement Protection Act of 2000 ("BIPA"), generally pays more for customers with predictably higher costs and uses principal hospital inpatient diagnoses as well as diagnosis data from ambulatory treatment settings (hospital outpatient department and physician visits). Under the risk-adjustment methodology, all health benefit organizations must capture, collect, and submit the necessary

diagnosis code information to CMS within prescribed deadlines.

HMO plans covered under Medicare Advantage contracts with CMS are renewed generally for a one-year term each December 31 unless CMS notifies the plan of its decision not to renew by August 1 of the year in which the contract would end, or the plan notifies CMS of its decision not to renew by the first Monday in June of the year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare Advantage business have been renewed for 2011.

Medicare Part D

All Medicare beneficiaries are eligible to receive assistance paying for prescription drugs through Medicare Part D. The drug benefit is not part of the traditional fee-for-service Medicare program, but rather is offered through private insurance plans. Medicare beneficiaries are able to choose and enroll in a prescription drug plan through Medicare Part D. Prescription drug coverage under Part D is voluntary. Fee-for-service beneficiaries may purchase Part D coverage from a stand-alone prescription drug plan (a "stand-alone PDP") that is included on a list approved by CMS.

Individuals who are enrolled in a Medicare Advantage plan that offers drug coverage must receive their drug coverage through the prescription drug plan offered by their Medicare Advantage plan ("MA-PD") and may not enroll in a stand-alone PDP. Any customer of a Medicare Advantage plan that enrolls in a stand-alone PDP is automatically disenrolled from the Medicare Advantage plan altogether, thereby resuming traditional fee-for-service Medicare coverage. Beneficiaries who are eligible for both Medicare and Medicaid, known as dual eligible beneficiaries, who have not enrolled in a MA-PD or a stand-alone PDP are automatically enrolled by CMS in an approved stand-alone PDP in their area.

The Medicare Part D prescription drug benefit is largely subsidized by the federal government and is additionally supported by risk-sharing with the federal government through risk corridors designed to limit the profits or losses of the drug plans and reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for customer demographics and risk factor payments.

The majority of our Humana Plan Customers receive prescription drug coverage through Medicare Part D. We are responsible for the costs of all pharmaceuticals not otherwise covered by beneficiary co-pays, deductibles and late enrollment penalties, including those costs that exceed any standard Part D coverage limits. Our capitation fee from Humana is intended to cover such costs.

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 customers. The additional premium for a dually-eligible beneficiary is based upon the estimated incremental cost CMS incurs, on average, to care for dual-eligible beneficiaries. The Medicare Modernization Act of 2003 (the "MMA") provides subsidies and reduced or eliminated deductibles for certain low-income beneficiaries, including dual-eligible individuals. Dual-eligible individuals receive their drug coverage from the Medicare program rather than the Medicaid program. Companies offering stand-alone PDP with bids at or below the regional weighted average bid resulting from the annual bidding process received a pro-rata allocation and automatic enrollment of the dual-eligible beneficiaries within their applicable region.

Healthcare Reform Legislation in 2010

The healthcare reform legislation is not directly applicable to us since we are not a Medicare Advantage plan. However, this legislation will directly impact Medicare Advantage plans such as Humana's, and, therefore, are expected to indirectly affect PSNs such as ours. See Item 1A. "Risk Factors - Reductions in Funding for Medicare Programs.…"

Healthcare Reform Legislation

The United States' healthcare system, including the Medicare Advantage Program, is subject to a broad array of new laws and regulations as a result of the Patient Protection and Affordable Care Act, which became law on March 23,

2010 which was shortly thereafter amended by the Health Care and Education Reconciliation Act of 2010, which became law on March 30, 2010 (collectively, the "Reform Acts"). The Reform Acts are considered by some to be the most dramatic change to the country's healthcare system in decades. This legislation made significant changes to the Medicare program and to the health insurance market overall. Among other things, the new laws limit Medicare Advantage payment rates, stipulate a prescribed minimum ratio for the amount of premium revenues to be expended on medical costs, give the Secretary of HHS the ability to deny Medicare Advantage plan bids that propose significant increases in cost sharing or decreases in benefits, and make certain changes to Medicare Part D. Because substantially all of our revenue is directly or indirectly derived from reimbursements generated by Medicare Advantage health plans, any changes that limit or reduce Medicare reimbursement levels, such as reductions in or limitations of reimbursement amounts or rates under programs, reductions in funding of programs, expansion of benefits without adequate funding, elimination of coverage for certain benefits, or elimination of coverage for certain individuals or treatments under programs, could have a material adverse effect on our business.

There are numerous steps required to implement the Reform Acts, and Congress may seek to alter or eliminate some of their provisions. Numerous legal challenges have also been raised to the Reform Acts that could alter or eliminate certain provisions. Further, various health insurance reform proposals are also emerging at the state level. Because of the unsettled nature of these reforms and numerous steps required to implement them, we cannot predict what additional health insurance reforms will be implemented at the federal or state level.

Premium Payment Benchmarks and Caps - The Reform Acts freeze the 2011 Medicare Advantage payment benchmarks at 2010 levels. Thereafter, pursuant to the schedule described below, the Reform Acts reduce payment benchmarks with respect to each county to an amount that is between 95% and 115% of per beneficiary cost of traditional fee-for–service Medicare costs. The new benchmarks will be phased in over 3 years in counties in which the impact is estimated to be less than $30 per member per month ("PMPM"), 4 years in counties in which the phased-in change in payments is estimated to be at least $30 PMPM but less than $50 PMPM, and 6 years in counties in which the phased-in change in payments is estimated to be $50 PMPM or more.

In the counties in which we operate, approximately 60% of our membership is in counties that will be benchmarked at 100% of fee-for-service Medicare rates with the remainder in counties that will be benchmarked at 95% of fee-for-service Medicare rates. The transition period for the counties in which we operate is between two and six years. We project that the foregoing benchmark adjustments will have a depressive effect on the payment benchmarks utilized by CMS in the counties in which we operate.

The Reform Acts also places a cap on payments to a plan, including the bonuses described below, to the 2010 level of payment.

Quality Rating, Rebates and Bonuses - CMS currently rates the relative quality of plans annually, on a one to five-star scale, as a way of monitoring plan quality and aiding Medicare beneficiaries who are considering enrolling in plans. Under the Reform Acts and related regulations, the quality rating of a plan can directly effect its entitlement to Cost Saving Rebates and various bonuses.

The Reform Acts provide different Cost Saving Rebate percentages based upon a plan's quality rating. See "Bidding Process" below. Plans with less than 3.5 stars are entitled to a 50% Cost Saving Rebate; plans with 3.5 or 4.0 stars are entitled to a 65% Cost Saving Rebate and plans with a 4.5 or 5.0 stars are entitled to a 70% Cost Saving Rebate.

The Reform Acts also generally provide bonuses to plans receiving 4.0 or more stars with bonus payments of 1.5% in 2012, 3.0% in 2013 and 5% in 2014 and later years.

In November 2010, CMS announced a three-year demonstration beginning in 2012, aimed at providing Medicare Advantage plans with additional financial incentives to provide high-quality care. In 2012, plans with 5 stars will receive a bonus of up to 5% while plans with 4 stars will receive a bonus of up to 4% and plans with 3 stars will receive a bonus of up to 3%. The amount paid is reduced by the phase in period described in the "Premium, Payment Benchmarks and Caps" above. Approximately 81% of our customers are in Humana Plans that have a star rating above 3.0.

Risk Adjustment - Recognizing a perceived trend among Medicare Advantage plans to report information that increases enrollees' risk scores relative to similar beneficiaries in traditional fee-for-service Medicare, CMS reduced risk scores for the 2010 plan year and has announced a 3.41% reduction in risk scores for the 2011 plan year. The Reform Acts extend the authority of CMS to continue to adjust the risk scores, and requires CMS to adjust risk scores, beginning in 2014, with a reduction of at least 5.7% in 2019 and future years, subject to future directives of the Secretary of HHS.

Enrollment Period - Through 2010, the annual election period for Medicare beneficiaries to join, change or drop a Medicare Advantage plan was November 15 through December 31. Enrollment prior to December 31 is generally effective as of January 1 of the following year. In 2011, the annual election period for 2012 will begin October 15 and end on December 7.

In addition to the annual election period, prior to the Reform Acts, Medicare Advantage beneficiaries also had a yearly Open Enrollment Period (OEP) from January 1 to March 31. This Medicare Advantage OEP allowed beneficiaries another opportunity to join a Medicare Advantage plan, change plans or disenroll from an MA plan. The healthcare reform legislation of 2010 eliminated the OEP and replaced it with a Medicare Advantage Disenrollment Period. In 2011 and thereafter, the Disenrollment Period will be from January 1 to February 14. During this period Medicare Advantage plan members will only be allowed to disenroll from their current plan and rejoin original fee-for-service Medicare.

After the disenrollment period ends, generally only seniors turning 65 during the year, Medicare beneficiaries who permanently relocate to another service area, dual-eligible beneficiaries, others who qualify for special needs plans, and employer group retirees will be permitted to enroll in or change health plans during the year. In certain circumstances, such as the bankruptcy of a health plan, CMS may offer a special election period during which the customers affected are allowed to change plans.

The Reform Acts provide that commencing in 2012 CMS will also allow Medicare beneficiaries who are enrolled in a Medicare Advantage plan with a quality rating (discussed further below) of 4.5 stars or less to enroll in 5 star rated Medicare Advantage plan at any time during the benefit year.

Bidding Process - Since January 1, 2006, CMS has used a rate calculation system for Medicare Advantage plans based on an annual competitive bidding process that allows the federal government to share in any cost savings achieved by Medicare Advantage plans, relative to a statutory payment rate. The statutory payment rate for each county, which is primarily based on CMS's estimated per beneficiary traditional fee-for-service expenses, is commonly known as the "benchmark" amount. Medicare Advantage plans 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. Prior to 2011, if the bid was less than the subject benchmark, Medicare paid the plan its bid amount, adjusted based on county of residence and customers' risk scores. In addition, the plan would earn a rebate (a "Cost Savings Rebate") equal to 75% of the amount by which the benchmark exceeded the bid. Plans are required to use the Cost Savings Rebate to provide beneficiaries with extra benefits, reduced cost sharing, or reduced premiums, including premiums for MA-PD and other supplemental benefits and CMS has the right to audit the use of these proceeds. As a result of the Reform Acts, commencing in 2011 the Cost Savings Rebate percentage will vary between 50% and 70% based upon the quality rating of the subject plan. If a Medicare Advantage plan's bid is greater than the benchmark, the plan is required to charge a premium to enrollees equal to the difference between the bid amount and the benchmark, which can make such plans charging premiums less attractive to potential customers.

Cost Sharing Restrictions - The Reform Acts prohibit plans from imposing higher cost sharing requirements than traditional fee-for-service Medicare for various services, including chemotherapy, renal dialysis and skilled nursing care.

Restrictions on Use of Premium Revenue - Commencing in 2014, the Reform Acts require plans to expend 85% of the premium dollars they receive on direct care for patients and efforts to improve care quality. The penalties for non-compliance with this provision include monetary penalties and, in instances of non-compliance for two consecutive years, the plan may be required to suspend plan enrollment for three years. In instances of non-compliance for five consecutive years, the plan's contract with CMS may be terminated. The 85% target is not directly applicable to us since we are not a Medicare Advantage plan.

Independent Payment Advisory Board - The Reform Acts established a new Independent Payment Advisory Board to recommend ways to reduce Medicare spending if the increase in Medicare per capita growth exceeds certain targets.

Business Model

The Florida Medicare Advantage Market

We operate our PSN business in 16 Florida counties.

Over the last several decades, Florida has generally been a highly attractive, rapidly growing market. In April 2010, the Office of Economic & Demographic Research of the Florida Legislature projected a total population in Florida of over 18.8 million people. Those 65 and older in Florida are projected to be 3.3 million in 2010 and are forecast to increase to 4.5 million by 2020.

Behind only California, which has approximately 4.7 million Medicare eligible beneficiaries, Florida has the second largest Medicare eligible population in the U.S. with an estimated 3.3 million Medicare eligible beneficiaries. As of May 2010, California's Medicare Advantage penetration was approximately 36% while Florida's was 32%. Our Humana Agreements cover 30 Florida counties and we have established provider networks in 16 of these counties.

According to CMS data, as of December 2010, of the approximately 1.5 million Medicare eligible individuals in the counties in which we have established networks, approximately 29% are customers of Medicare Advantage plans. In the fourteen counties where we do not yet have provider networks, we believe that of the approximately 1.3 million Medicare eligible individuals in these counties, approximately 38% are customers of Medicare Advantage plans.

Providers Services Network

Physician Network

In the last quarter of 2010, we entered into definitive agreements to acquire the practices of three existing IPAs'. These practices included approximately 960 customers that are included in the number of Humana Participating Customers at December 31, 2010. On January 31, 2011 and February 28, 2011, we closed on the acquisitions of two practices with a total of 830 customers. The total purchase price for the three practices is $1.6 million, with a portion payable in cash at closing and the balance payable over the next 18 months.

At December 31, 2010, the PSN owned and operated ten primary care centers and an oncology practice. The primary care centers provide and arrange for medical care to approximately 28% of the PSN's customers at December 31, 2010. If all three practices discussed above had been acquired at December 31, 2010, the percentage of customers served by owned centers would have increased to 31%.

In addition, we expect to open a new primary care center in the spring of 2011.

The PSN contracts with IPAs to provide and manage care for our remaining customers. Some of these contracts provide for payment to the provider of a fixed per customer per month amount and require the providers to provide all the necessary primary care medical services to Humana Participating Customers. The monthly amount is negotiated and is subject to change based on certain quality metrics under the PSN's Partners In Quality ("PIQ") program, our proprietary care management model. Other contracts provide for payments on a fee for service basis, pursuant to which the provider is paid only for the services provided.

PIQ is our "pay for performance" program that measures performance based on quality metrics including customer satisfaction, disease state management of high-risk, chronically ill customers, frequency of physician-customer encounters, and enhanced medical record documentation. We believe that the PIQ program helps differentiate our PSN from other PSNs.

The contracts with our IPAs generally have one-year terms and renew automatically for one-year periods unless either party provides written notice at least 60 days prior to the end of the term. The IPA providers, during the term of their contract with the PSN, and for a period of six months after the expiration or termination of such contract, are generally prohibited from participating in any other PSN, HMO or other agreement which contracts directly or indirectly with the Medicare or Medicaid Program on a capitated or risk basis. The IPA providers are further prohibited during the term and for a period of six months after the expiration of the terms from encouraging or soliciting the Humana Participating Customers to change their primary care provider, disenroll from their health plan, or leave the PSN's network.

The PSN has established referral relationships with a large number of specialist physicians, ancillary service providers and hospitals throughout the PSN's service area that are under contract with Humana. These providers have contracted with Humana to deliver services to our PSN customers based on certain fee schedules and care requirements. Specialist physicians, ancillary service providers and hospitals are generally paid on a contractual fee-for-service basis. Certain specialist physicians dealing with a high volume of cases are paid on a capitated basis.

Patient Centered Medical Home Recognition

In February 2010, we were notified by the National Committee for Quality Assurance ("NCQA") that all eight of our owned primary care centers that applied to the NCQA have been recognized as a Level 3 National Physician Practice Connections® — Patient-Centered Medical Home™ (PPC®-PCMH™), the highest recognition available. We believe that our primary care centers were the first recognized Patient-Centered Medical Home ("PCMH") in Florida and that this recognition improves our competitive position. We plan to apply for NCQA recognition on our two remaining primary care centers and our oncology practice during 2011.

The PCMH is a developed approach to provide comprehensive medical care. Under this approach, care is delivered through a physician-led healthcare team which utilizes information technology and evidence-based medicine to enhance communication and customer access, improve clinical outcomes, and ensure continuity and coordination of care, thereby adding value to the healthcare consumer. We believe that our approach to care is philosophically and operationally aligned with the PCMH principles.

Humana Agreements

Pursuant to the Humana Agreements, the PSN provides, on a non-exclusive basis, healthcare services to Medicare beneficiaries in certain Florida counties.

Our PSN assumes full responsibility for the provision or management of all necessary medical care for each of the approximately 34,400 Humana Participating Customers covered by the Humana Agreements, even for services we do not provide directly. In return for the provision of these medical services, the PSN receives from Humana a capitation fee for each Humana Participating Customer established pursuant to the Humana Agreements. The amount we receive from Humana represents a substantial percentage of the monthly premiums received by Humana from CMS with respect to Humana Participating Customers.

For the 28,700 Humana Participating Customers covered under two of the network agreements, our PSN is responsible for the cost of all medical care provided. For the approximately 5,700 Humana Participating Customers covered by the remaining network agreement, our PSN and Humana share in the cost of inpatient hospital services and the PSN is responsible for the full cost of all other medical care provided to the Humana Participating Customers. To the extent the costs of providing such medical care are less than the related fees received from Humana; our PSN generates a gross profit. Conversely, if total medical expense exceeds the fees received from Humana, our PSN experiences a deficit in gross profit.

The Humana Agreements are also subject to changes to the covered benefits that Humana elects to provide to Humana Plan Customers and other terms and conditions.

For the term of the Humana Agreement covering 19,400 customers:

- Humana has agreed that it will not, with the exception of one existing service provider, enter into any new global risk agreements for Humana's Medicare Advantage HMO products; and

- The PSN has agreed that it will not enter into any global, full or limited risk contracts with respect to Medicare Advantage customers with any non-Humana Medicare Advantage HMO or provider sponsored organization in these two counties.

With respect to three counties in which we have approximately 9,300 customers, unless otherwise agreed to in writing by Humana, the PSN is restricted from entering into any risk contract with any other Medicare Advantage plan

through December 31, 2013.

The Humana Agreements and/or any individual physician in our primary care physician network may be immediately terminated by Humana, upon written notice, (i) if the PSN and/or any of the PSN physician's continued participation may adversely affect the health, safety or welfare of any Humana customer or bring Humana into disrepute; (ii) if the PSN or any of its physicians fail to meet Humana's credentialing or re-credentialing criteria; (iii) if the PSN or any of its physicians is excluded from participation in any federal healthcare program; (iv) if the PSN or any of its physicians engages in or acquiesces to any act of bankruptcy, receivership or reorganization; (v) if Humana loses its authority to do business in total or as to any limited segment or business (but only to that segment), or (vi) in accordance with Humana's policies and procedures. The PSN and Humana may also terminate two of the Humana Agreements covering a total of 25,100 customers upon 90 days' prior written notice (with a 60 day opportunity to cure, if possible) in the event of the other's material breach of the applicable Humana Agreement. These two agreements, which have one year terms and generally renew automatically each December 31, may also be terminated upon 180 day notice of non-renewal by either party. The Humana Agreement covering 9,300 customers has a five-year term expiring August 31, 2013 and will renew automatically for additional one-year periods upon the expiration of the initial term and each renewal term unless terminated upon 90 days notice prior to the end of the applicable term. After the initial five-year term, either party may terminate the agreement without cause by providing to the other party 120 days prior notice.

In addition, for the term plus one year for each of the Humana Agreements, the PSN and its affiliated providers will not, directly or indirectly, engage in any activities which are in competition with Humana's health insurance, HMO or benefit plans business, including obtaining a license to become a managed healthcare plan offering HMO or point of service ("POS") products, or (ii) acquire, manage, establish or have any direct or indirect interest in any provider sponsored organization or network for the purpose of administering, developing, implementing or selling government sponsored health insurance or benefit plans, including Medicare and Medicaid, or (iii) contract or affiliate with another licensed managed care organization, where the purpose of such affiliation is to offer and sponsor a HMO or POS products and where the PSN and/or its affiliated providers obtain an ownership interest in the HMO or POS products to be marketed, and (iv) enter into agreements with other managed care entities, insurance companies or provider sponsored networks for the provision of healthcare services to Medicare HMO, Medicare POS and/or other Medicare replacement patients at the same office sites or within five miles of the office sites where services are provided to the Humana Plan Customers.

Our Agreement with CarePlus

Our PSN has a network agreement with CarePlus Health Plans, Inc. ("CarePlus"), a Medicare Advantage HMO in Florida wholly-owned by Humana, which agreement permits us to provide services to CarePlus customers in 22 Florida counties. At December 31, 2010, we provided services to approximately 370 CarePlus customers in 10 of these counties. From the establishment of our network agreement with CarePlus in August 2007 to January 31, 2010, the PSN received a monthly network administration fee for each CarePlus customer who selected one of the PSN physicians as his or her primary care physician (a "CarePlus Participating Customer"). Commencing February 1, 2010, the PSN began to receive a monthly capitation fee from CarePlus and assumed full responsibility for the cost of all medical services provided to each CarePlus Participating Customer. The capitation fee represents a substantial portion of the monthly premium CarePlus receives from CMS.

Appropriate Risk Coding

We strive to assure that our customers are assigned the proper risk scores. Our processes include ongoing training of medical staff responsible for coding and routine auditing of customer charts to assure risk-coding compliance. Customers with higher risk codes generally require more healthcare resources than those with lower risk codes. Proper coding helps to assure that we receive capitation fees consistent with the cost of treating these customers. Our efforts related to coding compliance are ongoing and we continue to dedicate considerable resources to this important discipline.

Claims Processing

Pursuant to the Humana Agreements, Humana, among other things, processes claims received from providers, including from our PSN, makes a determination as to whether and to what extent to allow such claims and makes payments for covered services rendered to Humana Participating Customers using Humana's claims processing systems, policies, procedures and guidelines. Humana provides notice to the PSN upon qualification of a claim and we have the opportunity within seven days of receipt of a claim to review such claim and approve, deny or modify the claim, as appropriate. Humana provides the PSN with electronic data and reports on a monthly basis, which are maintained at our executive offices. We statistically evaluate the data provided by Humana for a variety of factors including the number of customers assigned to the PSN, the reasonableness of revenue paid to us and the claims paid on our behalf. We also regularly monitor and measure Humana's estimates of claims incurred but not yet reported.

The PSN's claims suspense staff seeks to identify and correct non-qualifying claims prior to payment. After payments are made by Humana, the PSN's contestation staff is responsible for reviewing paid claims, identifying errors and seeking recoveries.

Utilization Management

Utilization review is a process whereby multiple data is analyzed to ensure that appropriate health services are provided in a cost-effective manner. Factors considered include the risks and benefits of a medical procedure, the cost of providing those services, specific payer coverage guidelines, and historical outcomes of healthcare providers such as physicians and hospitals.

Staff Training

We believe it is important, in what is a highly competitive healthcare marketplace, to retain and recruit top talent. We have entered into a formal program to better train and develop our leaders and staff. We believe this investment will have a positive return in terms of improved customer service, enhanced employee engagement and retention and, as a result, better outcomes and financial performance in future years.

PSN Growth Strategy

Our growth strategy for the PSN includes, among other things:

- increasing the volume of customers treated by the PSN physicians through enhanced marketing efforts;
- expanding the PSN's network of providers to include additional physician practices;
- acquiring existing physician practices;
- opening new practices; and
- acquiring other PSNs.

Increasing Customer Volume

We believe the PSN's existing network of providers has the capacity to care for additional Humana Plan Customers and could realize certain additional economies of scale if the number of Humana Plan Customers utilizing the network increased. We seek to increase the number of customers using the PSN network through the general marketing efforts of Humana and through our own targeted marketing efforts towards Medicare eligible customers.

Selectively Expanding Our Network of Physician Practices Including Acquisition of Existing Physician Practices or Other Provider Services Networks

Within our existing geographic markets, we are seeking to add additional physician practices to the PSN's existing network either through acquisition of an unaffiliated primary care practice, acquisition of an IPA practice, acquisition of another PSN or opening new primary care offices. We identify and select opportunities based in large part on the following broad criteria:

- a history of profitable operations or a perceived synergy such as opportunities for economies of scale through a consolidation of management or service provision functions;
- a high concentration of Medicare patients;
- a geographic proximity to underserved areas within our service regions; and

- a geographic proximity to our current operations.

As previously discussed, during the first two months of 2011, we acquired two IPA practices and anticipate the acquisition of one additional practice in March of 2011. In addition, we plan to open a new primary care center in the spring of 2011.

PSN Competition

Some of our direct competitors in the PSN industry, all of which are operating in Florida are Continucare Corporation, MCCI, Primary Care Associates, Inc., and Island Doctors. See Item 1A "Risk Factors – Our Industry is Already Very Competitive…"

Health Maintenance Organization

Between July 2005 and August 2008, we operated the HMO through our wholly-owned subsidiary, Metcare Health Plans, Inc.

On August 29, 2008 (the "Closing Date"), we completed the sale of all of the outstanding capital stock of the HMO to Humana Plan, Inc. pursuant to the terms of the Stock Purchase Agreement, dated as of June 27, 2008, by and between the Company and Humana Plan, Inc. for a cash purchase price of approximately $14.6 million (the "Purchase Price"). We recognized a gain on the sale of the HMO of approximately $5.9 million in 2008.

Upon closing, approximately ten percent of the Purchase Price was deposited in escrow to be held for 24 months to secure our payment of any post-closing adjustments, described below, and indemnification obligations. In September 2010, the $1.4 million escrow deposit was released.

The Purchase Price was subject to positive or negative post-closing adjustment based upon the difference between the HMO's estimated closing net equity, which was approximately $5.1 million, and the HMO's actual net equity as of the Closing Date as determined at December 31, 2009 (the "Closing Net Equity").

In April 2010, the Closing Net Equity was finalized and we received the final payment. This settlement resulted in additional gain on the sale of the HMO of $62,000 in 2010. The gain on sale in 2009 of $1.3 million includes gains from the closing net equity settlement for the HMO and the settlement of certain liabilities of the HMO in 2009 at amounts lower than the liability recorded at the Closing Date.

Concurrent with the sale, the PSN and Humana entered into the IPA Agreement to provide or coordinate the provision of healthcare services to the HMO's customers pursuant to a capitation arrangement.

In connection with the sale, we paid certain of the employees of the HMO stay bonuses or termination payments. We recognized and paid all of these costs, totaling $1.6 million, in the third quarter of 2008.

The following discussion generally summarizes the HMO's business as operated by us prior to its sale.

At the time of its sale, the HMO was offering its Medicare Advantage health plan in 13 Florida counties and providing services to 7,400 customers.

The HMO's Medicare Advantage customers did not pay a monthly premium in 2008. In most cases, the HMO customers were subject to co-payments and deductibles, depending upon the market and level of benefits. Except in limited cases, including emergencies, our HMO customers were required to use primary care physicians within the HMO's network of providers and generally received referrals from their primary care physician in order to see a specialist or ancillary provider.

Pursuant to the HMO's contract with CMS, the HMO had agreed to provide services to Medicare beneficiaries pursuant to the Medicare Advantage program. Under this contract, CMS paid the HMO a capitation payment based on the number of customers enrolled, which payment was adjusted for demographic and health risk factors. Inflation,

changes in utilization patterns and average per capita fee-for-service Medicare costs were also considered in the calculation of the capitation payment by CMS.

Insurance Arrangements

We rely upon insurance to protect us from many business risks, including medical malpractice, errors and omissions and certain significantly higher than average customer medical expenses. For example, to mitigate our exposure to high cost medical claims, we have reinsurance arrangements that provide for the reimbursement of certain customer medical expenses. In 2011, the per customer per year deductible for 5,700 PSN customers will be $40,000, with a $225,000 deductible for all other customers. Both policies have a maximum annual benefit per customer per policy of $1.0 million. Although we maintain insurance of the types and in the amounts that we believe are reasonable, there can be no assurances that the insurance policies maintained by us will insulate us from material expenses and/or losses in the future.

Employees

As of December 31, 2010, we had 226 full-time employees, 32 of which are on our corporate staff and 194 of which are employed by the PSN. None of our employees are covered by a collective bargaining agreement or are represented by a labor union. We consider our employee relations to be good.

Government Regulation

Our operations are affected on a day-to-day basis by numerous federal and state legislative, regulatory and industry-imposed operational and financial requirements, which are administered by a variety of federal and state governmental agencies as well as by self-regulating associations and commercial medical insurance reimbursement programs. The laws and regulations governing our operations are generally intended for the benefit of health plan customers and providers and are intended to limit healthcare program expenditures. These laws and regulations, along with the terms of our contracts, regulate how we do business, what services we offer, and how we interact with Humana Participating Customers, CarePlus Participating Customers, affiliated providers and the public. The government agencies administering these laws and regulations have broad latitude to interpret and enforce them. We are subject to various governmental reviews, audits and investigations to verify our compliance with our contracts and applicable laws and regulations.

We believe that we are in material compliance with all government regulations applicable to our business. We further believe that we have implemented reasonable systems and procedures to assist us in maintaining compliance with such regulations. Nonetheless, we face a variety of regulatory related risks. See “Description of Business – Healthcare Reform Legislation in 2010”, See “Risk Factors - Reductions in Funding for Medicare Programs under the Recent Healthcare Reform Legislation…”, Reductions in Funding for Medicare Programs…”, “CMS Risk Adjustment Payment System…”, “Our Business Activities Are Highly Regulated…”, “The Healthcare Industry is Highly Regulated…”, “We Are Required to Comply with Laws…”

A summary of material aspects of the government regulations to which we are subject is set forth below.

Healthcare Reform Legislation of 2010

The Reform Acts made significant changes to the Medicare program and to the health insurance market overall. Among other things, the Reform Acts limit Medicare Advantage payment rates, stipulate a prescribed minimum ratio for the amount of premium revenues to be expended on medical costs, give the Secretary of HHS the ability to deny Medicare Advantage plan bids that propose significant increases in cost sharing or decreases in benefits, and make certain changes to Medicare Part D. See “Description of Business – Healthcare Reform Legislation in 2010.”

Federal “Fraud and Abuse” Laws and Regulations

Healthcare fraud and abuse laws at the federal and state levels regulate both the provision of services to government program beneficiaries and the submission of claims for services rendered to such beneficiaries. Individuals and organizations can be punished for submitting claims for services that were not provided, not medically necessary, provided by an improper person, accompanied by an illegal inducement to utilize or refrain from utilizing a service or product, or billed in a manner that does not comply with applicable governmental requirements. Federal and state governments have a range of criminal, civil and administrative sanctions available to penalize and remediate healthcare fraud and abuse, including recovery of amounts improperly paid, imprisonment, exclusion from participation in the Medicare/Medicaid programs, civil monetary penalties and suspension of payments. Fraud and abuse claims may be initiated and prosecuted by one or more government entities and/or private individuals, and more than one of the available penalties may be imposed for each violation.

Laws governing fraud and abuse apply to virtually all healthcare providers (including the PSN Physicians and other physicians employed or otherwise engaged by the PSN) and the entities with which a healthcare provider does business.

Federal Anti-Kickback Law

The federal Anti-Kickback Law prohibits the knowing and willful offer, payment, solicitation, or receipt of any remuneration, overtly or covertly, in cash or in kind, to reduce or reward (i) referrals of goods, facilities, items or services reimbursable (in whole or in part) by a federal healthcare program (including, without limitation, Medicare and/or Medicaid), or (ii) the purchasing, leasing, ordering, or arranging for or recommending the purchasing, leasing or ordering of such goods, facilities, items or services. Violations of the Anti-Kickback Law are punishable by imprisonment, criminal fines, civil monetary penalties, exclusion from care programs and forfeiture of amounts collected in violation of such laws. "Remuneration" is defined broadly and includes virtually all economic arrangements involving hospitals, physicians and other healthcare providers, and any third party including joint ventures, space and equipment rentals, purchases of physician practices and management and personal services contracts.

However, in response to the breadth of the Anti-Kickback Law and a concern that it prohibited some common and appropriate arrangements, regulatory "safe harbors" were established such that if a particular transaction or relationship satisfied all of the requirements of a particular safe harbor, the transaction or relationship will be protected from prosecution under the Anti-Kickback Law. Further, the Anti-Kickback Law is an intent-based statute, meaning that the failure of an arrangement to meet all of the requirements of a safe harbor does not render such arrangement illegal per se. Rather, those arrangements that do not satisfy the requirements of a safe harbor will be subject to review on a case-by-case basis to determine whether the parties involved possessed the requisite improper intent.

Physician Incentive Plan Regulations

CMS has promulgated regulations that prohibit health plans with Medicare contracts from making 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 also impose disclosure, patient satisfaction monitoring and other requirements relating to physician incentive plans including requirements that govern incentive plans involving bonuses or withholdings that could result in a physician being at "substantial financial risk" as defined in Medicare regulations.

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 prohibits any party from knowingly presenting, or causing to be presented, a false or fraudulent request for payment from the federal government, or making a false statement or using 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 Law or the federal Ethics on Patient Referrals Law ("Stark Law") 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 as well as by imprisonment for up to five years. 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 customer) 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.

Florida Fraud and Abuse Regulations

Florida enacted "The Patient Brokering Act" which imposes criminal penalties, including jail terms and fines, for offering, soliciting, receiving or paying any commission, bonus, rebate, kickback, or bribe, directly or indirectly in cash or in kind, or engaging in any split-fee arrangement, in any form whatsoever, to induce the referral of customers or patronage from a healthcare provider or healthcare facility. The Florida statutory provisions regulating the practice

of medicine include similar language as grounds for disciplinary action against a physician.

Restrictions on Physician Referrals

The Stark Law, enacted as part of the Social Security Act, prohibits a physician from referring Medicare or Medicaid beneficiaries to an entity for the furnishing of "designated health services," which includes a broad range of inpatient and outpatient healthcare services, if the physician (or the physician's immediate family member) has a direct or indirect "financial relationship" with the entity. The Stark Law also prohibits an entity from billing Medicare or Medicaid for services furnished pursuant to a prohibited referral. A financial relationship is defined broadly to include a direct or indirect ownership or investment in, or compensation relationship with, a healthcare entity. The Stark Law, and the regulations promulgated thereunder, contains certain exceptions that permit referrals that would otherwise be prohibited if the parties comply with all of the requirements of the applicable exception. The sanctions under the Stark Law include denial of claims and repayment of claims previously paid, civil monetary penalties and exclusions from participation in the Medicare programs.

Privacy Laws

The privacy, security, and use and disclosure of patient health information is subject to federal and state laws and regulations, including the Healthcare Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations. Final regulations with respect to the privacy of certain individually identifiable health information (the "Protected Health Information") became effective in April 2003 (the "Privacy Rule"). The Privacy Rule specifies authorized or required uses and disclosures of the Protected Health Information, as well as the rights patients have with respect to their health information. The Privacy Rule also provides that to the extent that state laws impose stricter privacy standards than the HIPAA privacy rule, such standards are not preempted, requiring compliance with any stricter state privacy law. In addition, in October 2002, the electronic data standards regulations under HIPAA became effective. The final HIPAA security rule became effective in February 2003, and established security standards with respect to Protected Health Information transmitted or maintained electronically. These regulations establish uniform standards relating to data reporting, formatting, and coding that many healthcare providers and health plans must use when conducting certain transactions involving health information.

HIPAA added a new provision to an existing criminal statute that prohibits the knowing and willful falsification or concealment of a material fact or the making of a materially false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services. HIPAA established criminal sanctions for healthcare fraud and applies to all healthcare benefit programs, whether public or private. HIPAA also imposes sanctions and fines for unintentional disclosure of Protected Health Information.

Clinic Licensure

The State of Florida Agency for Healthcare Administration ("AHCA") requires us to license each of our physician practices individually as healthcare clinics. Each physician practice must renew its healthcare clinic licensure biennially.

Occupational Safety and Health Administration ("OSHA")

In addition to OSHA regulations applicable to businesses generally, we must comply with, among other things, the OSHA directives on occupational exposure to blood borne pathogens, the federal Needlestick Safety and Prevention Act, OSHA injury and illness recording and reporting requirements, federal regulations relating to proper handling of laboratory specimens, spill procedures and hazardous waste disposal, and patient transport safety requirements.

The Medicare Improvements for Patients and Providers Act of 2008

The Medicare Improvements for Patients and Providers Act of 2008 ("MIPPA") addressed several aspects of the Medicare program. With respect to Medicare Advantage and Medicare Part D plans, MIPPA increased restrictions on marketing and sales activities, including limitations on compensation systems for agents and brokers, limitations on solicitation of beneficiaries, and prohibitions regarding many sales activities.

Our Executive Officers

Set forth below are: (1) the names and ages of our executive officers at February 1, 2011, (2) all positions with the Company presently held by each such person and (3) the positions held by, and principal areas of responsibility of, each such person during the last five years.

Michael M. Earley	55	Chairman of the Board and Chief Executive Officer
Jose A. Guethon, M.D.	48	Chief Operating Office and President
Robert J. Sabo, CPA.	60	Chief Financial Officer
Roberto L. Palenzuela, Esq.	47	General Counsel and Secretary

MICHAEL M. EARLEY has served as our Chief Executive Officer since March 2003. He also served as Chairman of the Board since September 2004, with the exception of the period between December 7, 2009 to April 23, 2010. He previously served as a member on our Board of Directors from June 2000 to December 2002. From January 2002 until February 2003, Mr. Earley was self-employed as a corporate consultant. Previously, from January 2000 through December 2002, he served as Chief Executive Officer of Collins Associates, an institutional money management firm. From 1997 through December 1999, Mr. Earley served as Chief Executive Officer of Triton Group Management, a corporate consulting firm. From 1986 to 1997, he served in a number of senior management roles, including CEO and CFO of Intermark, Inc. and Triton Group Ltd., both publicly traded diversified holding companies and from 1978 to 1983, he was an audit and tax staff member of Ernst & Whinney. From 2002 until its sale in 2006, Mr. Earley served as a director and member of the audit committee of MPower Communications, a publicly traded telecommunications company. Mr. Earley received his undergraduate degrees in Accounting and Business Administration from the University of San Diego.

JOSE A. GUETHON, M.D. has served as our Chief Operating Officer and President since September 2009. Prior to his appointment, he served as President of the PSN since January 2008. Dr. Guethon initially joined us in October 2001 and has served in a variety of positions, including as Medical Director and Staff Physician from October 2001 through June 2004, as Senior Vice President of Utilization and Quality Improvement from June 2004 through January 2006 and as Chief Medical Officer of our HMO from January 2006 through December 2006. Dr. Guethon has approximately 15 years of healthcare experience both in clinical and administrative medicine, and is board-certified in family practice. Prior to joining us, Dr. Guethon served as the Regional Medical Director for JSA Healthcare Corporation, a provider services network located in Tampa, Florida from April 2001 through October 2001 and as the Medical Director of Humana's Orlando market operations from April 1998 through April 2001. Dr. Guethon earned his undergraduate degree from the University of Miami, his doctorate in medicine degree from the University of South Florida College of Medicine, and completed an MBA program at Tampa College.

ROBERT J. SABO, C.P.A. has served as our Chief Financial Officer since November 15, 2006. Mr. Sabo has over 35 years of financial expertise focused substantially in the Florida healthcare industry. From November 2003 to October 2006, he was the Chief Financial Officer of Hospital Partners of America, LLC, a privately held North Carolina healthcare services and hospital partnership company, where his duties included the day to day financial operations of the organization as well as the company's significant business development and merger and acquisition work. He began his career as a CPA in South Florida with Ernst & Young in 1972, and was admitted to the partnership in 1984. He was the Market Leader of the Health Science Practice of the Carolinas from January 1999 to June 2003. Mr. Sabo graduated with a B.B.A. in Accounting from the University of Miami. He is a Certified Public Accountant and a member of the American Institute of Certified Public Accountants.

ROBERTO L. PALENZUELA, ESQ. has served as General Counsel and Secretary since March 2004. Prior to joining us, Mr. Palenzuela served as General Counsel and Secretary of Continucare Corporation, a publicly traded

primary care physician services company, from May 2002 through March 2004. From 1994 to 2002, Mr. Palenzuela served as an officer and director of Community Health Plan of the Rockies, Inc., a privately owned health maintenance organization based in Denver, Colorado. Community Health Plan of the Rockies, Inc. filed for protection under Chapter 11 of the federal bankruptcy laws on November 15, 2002, and was released from Chapter 11 on December 16, 2002. From March 1999 through June 2001, Mr. Palenzuela served as General Counsel of Universal Rehabilitation Centers of America, Inc. (n/k/a Universal Medical Concepts, Inc.), a privately owned physician practice management company. Mr. Palenzuela received his Bachelors Degree in Business Administration from the University of Miami in 1985 and his law degree from the University of Miami School of Law in 1988.

ITEM 1A. RISK FACTORS

Reductions in Funding for Medicare Programs and Other Provisions Under the Recent Healthcare Reform Legislation and Future Related Regulations Could Have a Material Adverse Effect on Our Business, Revenue and Profitability

The Reform Acts made significant changes to the Medicare program and to the health insurance market overall. A number of provisions of healthcare reform legislation took effect September 23, 2010, and other provisions take effect between 2011 and 2018. Potentially adverse provisions include:

- Medicare Advantage benchmarks for 2011 have been frozen at 2010 levels. Beginning in 2012, Medicare Advantage benchmark rates will be phased down from current levels to levels that are between 95% and 115% of fee-for-service costs, depending on a plan's geographic area. Plans receiving certain quality ratings by CMS will be eligible for bonus rate increases.

- Rebates received by Medicare Advantage plans that "underbid" based on payment benchmarks will be reduced, with larger reductions for plans failing to receive certain quality ratings.

- The Secretary of HHS is granted explicit authority to deny Medicare Advantage plan bids that propose significant increases in cost sharing or decreases in benefits.

- Beginning in 2014, Medicare Advantage plans with medical loss ratios below 85% will be required to pay a rebate to the Secretary of HHS. The Secretary will halt enrollment in any plan failing to meet this ratio for three consecutive years, and terminate any plan failing to meet the ratio for five consecutive years.

- Beginning January 1, 2011, cost-sharing for certain services (such as chemotherapy and skilled nursing care) will be limited to the cost-sharing permitted under traditional Medicare.

- Prescription drug plans will be required to cover all drugs on a list developed by the Secretary of HHS, and the Part D subsidy for high-income beneficiaries will be reduced.

Substantially all of our revenue is directly or indirectly derived from the monthly premium payment from CMS that is paid to Humana. As a result, our business and results of operations are dependent on government funding levels for Medicare Advantage programs. Any changes that limit or reduce Medicare reimbursement levels, such as reductions in or limitations of reimbursement amounts or rates under programs, reductions in funding of programs, expansion of benefits without adequate funding, elimination of coverage for certain benefits, or elimination of coverage for certain individuals or treatments under programs, could have a material adverse effect on our business.

Due to the Reform Acts' recent passage, scope and complexity, the unsettled nature of the reforms and the numerous steps required to implement them, and our inability to predict or dictate how Humana, CarePlus, our customers and/or our various direct and indirect competitors will react to the Reform Acts, we believe that we have limited ability to predict the direct and indirect effects of the Reform Acts upon the Medicare Advantage industry and us. For instance, although we anticipate that we will experience a decline in per beneficiary payment rates under the Reform Acts, we also anticipate the impact of such reduction on us will be mitigated, by some indeterminate amount by some of the following factors: enhanced medical management that will reduce the cost of care, reduced plan benefit offerings, increased customer co-pays and deductibles, the potential for plan quality bonuses, improved plan risk score compliance and/or other factors. We note that, although we are seeking to implement various operational and strategic initiatives with respect to the Reform Acts, our ability to anticipate and effectuate certain initiatives is significantly restricted since we have limited ability to influence, among other things, Humana's marketing efforts to increase enrollment in the plans that we serve, the plan benefits offered by Humana, the plan co-pays and deductibles set by

Humana and/or the quality ratings received by the Humana plans that we serve. If we fail to effectively implement our operational and strategic initiatives with respect to the Reform Acts for any reason, it is reasonably possible that our business may be materially adversely affected by the Reform Acts and related regulations.

As a result, changes to Medicare Advantage health plan reimbursement rates stemming from the Reform Acts as well as newly enacted and future regulations adopted in connection therewith may negatively impact our business, revenue and profitability. In addition, the Reform Acts establish a Medicare shared savings program for Accountable Care Organizations (ACOs) to take effect beginning in January 2012. Under this shared savings program, the Secretary of HHS may contract with eligible organizations, including group medical practices, to be accountable for the quality, cost and overall care of Medicare beneficiaries assigned to the ACO. Participating ACOs that meet specified quality performance standards will be eligible to share in any savings below a specified benchmark amount. The Secretary of HHS is also authorized, but not required, to use capitation payment models with ACOs. The development and expansion of ACOs has the potential to adversely impact our business, revenue and profitability.

There are numerous steps required to implement the Reform Acts, and Congress may seek to alter or eliminate some of the provisions described above. Numerous legal challenges have also been raised to the Reform Acts that could alter or eliminate certain provisions. Further, various health insurance reform proposals are also emerging at the state level. Because of the unsettled nature of these reforms and numerous steps required to implement them, we cannot predict what additional health insurance reforms may be implemented at the federal or state level, or the effect that any future legislation or regulation will have on our business. However, the enacted reforms as well as future legislative changes may have a material adverse effect on our results of operations, including lowering our reimbursement rates and increasing our expenses.

Our Operations are Dependent on Humana and, At Times, Their and Our Economic Interests May Diverge.

For the year ended December 31, 2010, approximately 99.5% of our revenue was earned through the Humana Agreements. We expect that, going forward, substantially all of our revenue will continue to be derived under the Humana Agreements. Humana may immediately terminate any of the Humana Agreements and/or any individual physician credentialed under the Humana Agreements upon the occurrence of certain events. Humana may also amend the material terms of the Humana Agreements under certain circumstances. See “Item 1. Business- Humana Agreements” for a detailed discussion of the Humana Agreements. Failure to maintain the Humana Agreements on favorable terms, for any reason, would materially adversely affect our results of operations and financial condition. A material decline in enrollees in Humana’s Medicare Advantage program could also have a material adverse effect on our results of operations.

Notwithstanding Humana and our current shared interest in providing service to Humana Participating Customers enrolled in Humana’s Medicare Advantage Plans, Humana and we have different and, at times, opposing economic interests. Humana provides a wide range of health insurance services across a wide range of geographic regions, utilizing a vast network of providers. As a result, Humana and we may have different views regarding the proper pricing of our services and/or the proper pri