AMERICAN MEDICAL SECURITY GROUP INC
Form 10-Q
May 06, 2004

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

[X] Quarterly Report Pursuant To Section 13 Or 15(d) Of The Securities Exchange Act Of 1934 FOR THE QUARTERLY PERIOD ENDED MARCH 31, 2004
OR
[ ] 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 1-13154

AMERICAN MEDICAL SECURITY GROUP, INC.
(Exact name of Registrant as specified in its charter)

| WISCONSIN | 39-1431799 |
|---|---|
| (State of Incorporation) | (I.R.S. Employer Identification No.) |
| 3100 AMS BOULEVARD<br>GREEN BAY, WISCONSIN | 54313 |
| (Address of principal executive offices) | (Zip Code) |

Registrant's telephone number, including area code: (920) 661-1111

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 _____

Indicate by check mark, whether the registrant is an accelerated filer (as defined in Exchange Act Rule 12b-2 of the Exchange Act).

Yes __X__ No _____

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

Common stock, no par value, outstanding as of April 30, 2004: 13,554,383 shares

AMERICAN MEDICAL SECURITY GROUP, INC.

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PART I FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

AMERICAN MEDICAL SECURITY GROUP, INC.

CONDENSED CONSOLIDATED BALANCE SHEETS

| (THOUSANDS, EXCEPT SHARE DATA) | March 31, 2004 |
|---|---|
| | (Unaudited) |
| ASSETS | |
| Investments: | |
| Fixed maturity securities available for sale, at fair value | $ 313,813 |

| | |
|---|---|
| Fixed maturity securities held to maturity, at amortized cost | 3,170 |
| Trading securities, at fair value | 1,582 |
| Total investments | 318,565 |
| Cash and cash equivalents | 18,716 |
| Property and equipment, net | 37,441 |
| Goodwill | 32,138 |
| Other intangibles, net | 1,794 |
| Other assets | 44,594 |
| Total assets | $ 453,248 |
| LIABILITIES AND SHAREHOLDERS' EQUITY | |
| Liabilities: | |
| Medical and other benefits payable | $ 123,426 |
| Advance premiums | 16,902 |
| Payables and accrued expenses | 22,539 |
| Notes payable | 30,158 |
| Other liabilities | 28,436 |
| Total liabilities | 221,461 |
| Shareholders' equity: | |
| Common stock (no par value, $1 stated value, 50,000,000 shares authorized, 16,654,315 issued and 13,549,383 outstanding at March 31, 2004, 16,654,315 issued and 13,511,183 outstanding at December 31, 2003) | 16,654 |
| Paid-in capital | 194,426 |
| Retained earnings | 43,167 |
| Accumulated other comprehensive income (net of taxes of $4,776 at March 31, 2004 and $3,302 at December 31, 2003) | 8,869 |
| Treasury stock (3,104,932 shares at March 31, 2004 and 3,143,132 shares at December 31, 2003, at cost) | (31,329) |
| Total shareholders' equity | 231,787 |
| Total liabilities and shareholders' equity | $ 453,248 |

SEE ACCOMPANYING NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS



AMERICAN MEDICAL SECURITY GROUP, INC.

CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS (Unaudited)

| (THOUSANDS, EXCEPT PER COMMON SHARE DATA) | Three Ma 2004 |
|---|---|
| REVENUES | |
| Insurance premiums | $ 177,72 |

| | |
|---|---|
| Net investment income | 3,53 |
| Net realized investment gains | 6 |
| Other revenue | 4,24 |
| Total revenues | 185,57 |
| EXPENSES | |
| Medical and other benefits | 113,16 |
| Selling, general and administrative | 54,52 |
| Interest | 22 |
| Amortization of intangibles | 16 |
| Total expenses | 168,07 |
| Income from continuing operations, before income tax expense | 17,49 |
| Income tax expense | 6,49 |
| Income from continuing operations | 10,99 |
| Loss from discontinued operations | |
| Net income | $ 10,99 |
| Earnings (loss) per common share - basic: | |
| Income from continuing operations | $ 0.8 |
| Loss from discontinued operations | |
| Net income | $ 0.8 |
| Earnings (loss) per common share - diluted: | |
| Income from continuing operations | $ 0.7 |
| Loss from discontinued operations | |
| Net income | $ 0.7 |

SEE ACCOMPANYING NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS



AMERICAN MEDICAL SECURITY GROUP, INC.

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS (Unaudited)

| (THOUSANDS) | Three M Mar 2004 |
|---|---|

| | |
|---|---|
| OPERATING ACTIVITIES | |
| Net income | $ 10,999 |
| Adjustments to reconcile net income to net cash provided by (used in) operating activities: | |
| Depreciation and amortization | 2,230 |
| Net realized investment gains | (65) |
| Change in trading securities | (158) |
| Deferred income tax expense (benefit) | 1,564 |
| Changes in operating accounts: | |
| Other assets | 559 |
| Medical and other benefits payable | (6,383) |
| Advance premiums | 1,037 |
| Payables and accrued expenses | (1,560) |
| Other liabilities | 2,199 |
| Net cash provided by (used in) operating activities | 10,422 |
| INVESTING ACTIVITIES | |
| Purchases of available for sale securities | (27,879) |
| Proceeds from sale of available for sale securities | 16,026 |
| Proceeds from maturity of available for sale securities | 4,125 |
| Proceeds from maturity of held to maturity securities | 200 |
| Purchases of property and equipment | (1,588) |
| Proceeds from sale of property and equipment | - |
| Net cash used in investing activities | (9,116) |
| FINANCING ACTIVITIES | |
| Exercise of stock options | 121 |
| Purchase of treasury stock | - |
| Repayment of notes payable | - |
| Net cash provided by (used in) financing activities | 121 |
| Cash and cash equivalents: | |
| Net change | 1,427 |
| Balance at beginning of year | 17,289 |
| Balance at end of period | $ 18,716 |

SEE ACCOMPANYING NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS



AMERICAN MEDICAL SECURITY GROUP, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Unaudited)

MARCH 31, 2004

1. BASIS OF PRESENTATION

The accompanying unaudited condensed consolidated financial statements have been

prepared in accordance with accounting principles generally accepted in the United States for interim financial information and with the instructions to Form 10-Q and Article 10 of Regulation S-X. Accordingly, they do not include all of the information and footnotes required by accounting principles generally accepted in the United States ("GAAP") for complete financial statements. In the opinion of management, all adjustments (consisting of normal recurring adjustments) considered necessary for a fair presentation have been included. Operating results for the three months ended March 31, 2004 are not necessarily indicative of the results that may be expected for the year ending December 31, 2004. These condensed consolidated financial statements should be read in conjunction with the consolidated financial statements and footnotes thereto included in the American Medical Security Group, Inc. (the "Company") Annual Report on Form 10-K for the year ended December 31, 2003.

2. STOCK-BASED COMPENSATION

The Company has stock-based compensation plans for the benefit of eligible employees and directors of the Company, which are described more fully in Note 11 in the Company's 2003 Annual Report on Form 10-K. During the first quarter of 2004, the Company granted 20,700 shares of restricted stock to outside members of the Company's Board of Directors. As a result, the Company's first quarter 2004 statement of operations includes compensation expense of $24,000, net of tax.

The Company follows Accounting Principles Board Opinion No. 25, the intrinsic value method of accounting for stock-based compensation, where no compensation expense is recorded when the exercise price of the Company's employee stock options equals the market price of the underlying stock on the date of grant. The following table illustrates the pro forma net income and pro forma net income per share as if the Company had followed the fair value method of accounting for stock-based compensation under Statement of Financial Accounting Standards No. 123, ACCOUNTING FOR STOCK-BASED COMPENSATION ("Statement 123").

| (THOUSANDS, EXCEPT PER COMMON SHARE DATA) | Three Ma 2004 |
|---|---|
| Net income, as reported | $ 10,99 |
| Add: Stock-based compensation expense included in reported net income, net of tax | 2 |
| Deduct: Stock-based compensation expense in accordance with the fair value method of Statement 123, net of tax | (35 |
| Pro forma net income | $ 10,66 |
| Net income per common share, as reported: | |
| Basic | $ 0.8 |
| Diluted | $ 0.7 |
| Pro forma net income per common share: | |
| Basic | $ 0.7 |
| Diluted | $ 0.7 |

In determining compensation expense in accordance with Statement 123, the fair value of options was estimated at the date of grant using the Black-Scholes option valuation model, which is commonly used in estimating the fair value of traded options which have no vesting restrictions and are fully transferable. Option valuation models require the input of highly subjective assumptions including the expected stock price volatility and the expected life of the options. Since the Company's employee stock options have characteristics significantly different from those of traded options, and because changes in the subjective input assumptions can materially affect the fair value estimates, in management's opinion, the existing models do not necessarily provide a reliable single measure of the fair value of its employee stock options.

3. DISCONTINUED OPERATIONS

During the third quarter of 2003, the Company sold all of the outstanding common shares of its preferred provider organization network subsidiary, Accountable Health Plans of America, Inc. ("AHP"). The network contracted with more than 900 hospitals and 100,000 physicians in eight primary states: Arizona, Florida, Iowa, Nebraska, North Dakota, South Dakota, Texas and Wisconsin. Subject to the terms of the agreement, AHP will continue to provide network services to the Company for five years. At the time of the sale, AHP served approximately 13% of the Company's members. The period ended March 31, 2003 as presented in the Company's statements of operations has been reclassified to exclude the results of the discontinued networking business from reported income from continuing operations.

4. PHARMACY BENEFITS MANAGER SETTLEMENT

During the first quarter of 2004, the Company reached an agreement with its former pharmacy benefits manager settling a dispute related to pricing and prescription drug fees charged from 1995 through 2002. As a result of the settlement, the Company received a cash payment of $5.9 million, and the Company's first quarter 2004 financial results include a one-time gain of approximately $3.4 million or $0.23 per diluted share, net of taxes and other related expenses. Due to the fact that the settlement resulted in a refund of claim expenses, the Company's health segment loss ratio benefited by 3.0% during the first quarter of 2004.

5. EARNINGS PER COMMON SHARE ("EPS")

Basic EPS is computed by dividing earnings by the weighted average number of common shares outstanding. Diluted EPS is computed by dividing earnings by the weighted average number of common shares outstanding, adjusted for the effect of dilutive stock options.

The following table illustrates the computation of EPS for income from continuing operations and provides a reconciliation of the number of weighted average basic and diluted shares outstanding:

| | Three Ma |
|---|---|
| (THOUSANDS, EXCEPT PER COMMON SHARE DATA) | 2004 |

| | |
|---|---|
| Numerator: | |
| Income from continuing operations | $ 10,99 |
| Denominator: | |
| Denominator for basic EPS | 13,62 |
| Effect of dilutive employee stock options | 95 |
| Denominator for diluted EPS | 14,58 |
| Earnings per common share - income from continuing operations: | |
| Basic | $ 0.8 |
| Diluted | $ 0.7 |



Certain options to purchase shares of common stock were not included in the computation of diluted earnings per common share for the three months ended March 31, 2003 because the options' exercise prices were greater than the average market price of the outstanding common shares for the period and, therefore, the effect would be antidilutive.

6. COMPREHENSIVE INCOME

Under existing accounting standards, comprehensive income for the Company includes net income and unrealized gains and losses, net of income tax effects, on certain investments in debt and equity securities. Comprehensive income for the Company is calculated as follows:

| (THOUSANDS) | Three Ma 2004 |
|---|---|
| Net income | $ 10,99 |
| Unrealized gain on available for sale securities | 2,73 |
| Comprehensive income | $ 13,73 |

7. CONTINGENCIES

In February 2000, a class action lawsuit was filed against the Company in the state of Florida alleging that the Company failed to follow Florida law when in 1998 it discontinued writing certain health insurance policies and offered new policies to insureds. Plaintiffs claim that the Company wrongfully terminated coverage, improperly notified insureds of conversion rights and charged improper premiums for new coverage. Plaintiffs also allege that the Company's renewal rating methodology violated Florida law. In 2002, a Circuit Court Judge ruled against the Company and ordered the question of damages be tried at a later

date. The Company believes a trial could not be held before the fourth quarter of 2004. The Company believes its practices were in full compliance with Florida law and is vigorously defending itself in this lawsuit.

The Company is a defendant in a number of lawsuits in various states, primarily Alabama, alleging misrepresentation of the rating methodology used by the Company with respect to certain MedOne(R) products purchased by the plaintiffs. These lawsuits commonly seek unspecified damages for misrepresentation and emotional distress in addition to punitive damages. Some of these cases involve multiple plaintiffs. The cases are in various stages of litigation. The Company believes that these lawsuits are unfounded because the Company properly disclosed the nature of the products sold. The Company also believes the subject matter of the lawsuits falls under the primary jurisdiction of state insurance departments. The Company has reached an agreement of settlement regarding a class action lawsuit involving these issues in Alabama and Georgia. The settlement has received preliminary court approval, with final approval expected in September 2004. The Company is vigorously defending itself in the other pending actions.

The Company is involved in various other legal and regulatory actions occurring in the normal course of business. Based on current information, including consultation with outside counsel, management believes any ultimate liability in excess of amounts reserved that may arise from the above-mentioned and all other legal and regulatory actions would not have a material adverse effect on the Company's consolidated financial position or results of operations. However, management's evaluation of the likely impact of these actions could change in the future and an unfavorable outcome could have a material adverse effect on the Company's consolidated financial position, results of operations or cash flow of a future period.



8. SEGMENT INFORMATION

The Company has two reportable segments: 1) health insurance products; and 2) life insurance products. The Company's health insurance products consist of the following coverages related to preferred provider organization products: MedOne(R) (for individuals and families) and small group medical, self-funded medical, dental and short-term disability. Life products consist primarily of group term life insurance. The "All other" category includes operations not directly related to the business segments and unallocated corporate items (i.e., corporate investment income, interest expense on corporate debt, amortization of intangibles and unallocated overhead expenses). The reportable segments are managed separately because they differ in the nature of the products offered and in profit margins.

The Company evaluates segment performance based on income or loss before income taxes, excluding realized gains and losses on the Company's investment portfolio. The accounting policies of the reportable segments are the same as those used to report the Company's consolidated financial statements. Significant intercompany transactions have been eliminated prior to reporting reportable segment information.

A reconciliation of segment income before income taxes to consolidated income from continuing operations is as follows:

| SEGMENT SUMMARY | Three Ma |
|---|---|

| (THOUSANDS) | 2004 |
|---|---|
| Health segment | $ 15,46 |
| Life segment | 1,52 |
| All other | 51 |
| Income from continuing operations, before tax | $ 17,49 |

Operating results and statistics for each of the Company's segments are as follows:

| HEALTH SEGMENT | Three Ma |
|---|---|
| (THOUSANDS, EXCEPT MEMBERSHIP DATA) | 2004 |
| REVENUES | |
| Insurance premiums | $ 174,81 |
| Net investment income | 1,56 |
| Other revenue | 4,19 |
| Total revenues | 180,57 |
| EXPENSES | |
| Medical and other benefits | 112,56 |
| Selling, general and administrative | 52,54 |
| Total expenses | 165,11 |
| Income from continuing operations, before tax | $ 15,46 |
| Loss ratio | 64.4 |
| Expense ratio | 27.7 |
| Combined ratio | 92.1 |
| Health membership at end of period: | |
| Fully-insured medical | 269,69 |
| Self-funded medical | 44,40 |
| Dental | 222,11 |
| Total health membership | 536,21 |



| LIFE SEGMENT | Three Ma |
|---|---|

| (THOUSANDS, EXCEPT MEMBERSHIP DATA) | 2004 |
|---|---|
| REVENUES | |
| Insurance premiums | $ 2,91 |
| Net investment income | 12 |
| Other revenue | 5 |
| Total revenues | 3,08 |
| EXPENSES | |
| Medical and other benefits | 60 |
| Selling, general and administrative | 96 |
| Total expenses | 1,56 |
| Income from continuing operations, before tax | $ 1,52 |
| Loss ratio | 20.6 |
| Expense ratio | 31.3 |
| Combined ratio | 51.9 |
| Life membership at end of period | 132,43 |



ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

BUSINESS OVERVIEW

American Medical Security Group, Inc., together with its subsidiary companies (the "Company"), is a provider of individual and small employer group insurance products. The Company's principal product offerings are medical insurance for small employer groups and medical insurance marketed to individuals and their families ("MedOne(R)"). The Company also offers dental, life, prescription drug, disability and accidental death insurance, and provides self-funded benefit administration. The Company has two reportable segments: health insurance products (which accounted for approximately 98% of the Company's total premium revenues for the quarters ended March 31, 2004 and 2003) and life insurance products. The Company markets its products in 32 states and the District of Columbia through independent agents. The Company has approximately 75 sales managers and representatives located in sales offices throughout the United States to support the independent agents. The Company's products generally provide discounts to members that utilize preferred provider organizations with which the Company contracts.

FINANCIAL RESULTS SUMMARY

For the three months ended March 31, 2004, the Company reported net income of $11.0 million or $0.75 per diluted share compared to net income for the first

three months of the prior year of $6.5 million or $0.48 per diluted share. The increase in earnings primarily resulted from an agreement reached between the Company and its former pharmacy benefits manager settling a dispute related to pricing and prescription drug fees charged to the Company from 1995 through 2002 (the "PBM settlement"). As a result of the PBM settlement, the Company received a cash payment of $5.9 million, and the Company's first quarter 2004 financial results include a one-time gain of $3.4 million or $0.23 per diluted share, net of taxes and other related expenses. The remainder of the earnings increase is attributable to improved profit margins primarily from a lower loss ratio and slightly lower expense ratio.

INSURANCE PREMIUM REVENUE AND MEMBERSHIP

Insurance premium revenue for the three months ended March 31, 2004 decreased to $177.7 million from $179.1 million for the corresponding period in 2003. The decrease primarily resulted from a trend of declining membership. Total health membership declined from 552,303 members at March 31, 2003 to 536,215 members at March 31, 2004. Management believes the membership decrease from the prior year was due in large part to a drop in dental membership, competitive pressures and attrition among existing small employer groups resulting from a continued soft job market. The impact of rapidly rising health care costs and the cost of health insurance coverage continues to be a major challenge faced by individuals and small business owners, the Company's primary market.

To help mitigate the impact of rising health care costs, the Company has refined its product offerings, so that insurance consumers have a greater financial stake in their health care decisions. In exchange for higher deductibles and copayments, the Company's products attempt to offer more affordable premiums. This has resulted in a moderation of the premium increases realized by the Company from its continuing membership. The Company also has reorganized its sales and marketing unit to focus more management oversight on membership and revenue growth. The position of chief marketing officer has been eliminated and the vice president of sales will now report directly to the Company's president and chief executive officer. Former senior vice president and chief marketing officer Timothy O'Keefe has departed the Company.

INVESTMENT INCOME AND OTHER REVENUE

Net investment income was $3.5 million for the three months ended March 31, 2004, compared to $3.4 million for the same period in 2003. The slight increase in net investment income was due primarily to an increase in average invested assets during the period. Realized investment gains from the sale of securities for the three months ended March 31, 2004 were $0.1 million compared to $0.4 million in the prior year. Other revenue, which primarily consists of administrative fee income from claim processing on self-funded business and other administrative services, increased to $4.2 million for the three months ended March 31, 2004 from $4.0 million for the three months ended March 31, 2003.



LOSS RATIO

The health segment loss ratio for the first quarter of 2004 was 64.4%, compared to 68.1% for the first quarter of 2003. The improvement from the first quarter of the prior year is due primarily to the 3.0% impact of the PBM settlement. The remaining improvement in the health segment loss ratio was primarily due to strong performance of the Company's medical business. Excluding the PBM settlement, claim costs per member per month have increased slightly, but were surpassed by the increase in premiums per member per month. The health segment

loss ratio is impacted by a variety of factors including claim cost trends, product pricing and the cost of litigation. Management closely monitors developments in litigation and emerging trends in claims costs to determine the adequacy and reasonableness of the Company's related reserves, and adjusts such reserves when necessary. The loss ratio for the life segment was favorable at 20.6% for the three months ended March 31, 2004, compared with 26.7% for the corresponding period of the prior year.

SELLING, GENERAL AND ADMINISTRATIVE EXPENSE RATIO

The selling, general and administrative ("SG&A") expense ratio includes commissions and selling expenses, administrative expenses net of other revenues, and premium taxes and assessments. The SG&A expense ratio for the health segment for the three months ended March 31, 2004 was 27.7%. This compares to the first quarter of 2003 health segment SG&A expense ratio of 27.8%. General and administrative expenses decreased resulting from the Company's continued focus on administrative cost containment and process efficiencies in an effort to keep costs in line with revenues. Offsetting this decrease was an increase in commissions and selling expenses due to improved MedOne new member enrollment and the Company's investment in sales resources to support the Company's growth efforts.

LIQUIDITY AND CAPITAL RESOURCES

The Company's sources of cash flow consist primarily of insurance premiums, administrative fee revenue and investment income. The primary uses of cash include payment of medical and other benefits and SG&A expenses. Positive cash flows are invested pending future payments of medical and other benefits and other operating expenses. The Company's investment policies are structured to provide sufficient liquidity to meet anticipated payment obligations.

The Company's investment portfolio consists primarily of investment grade bonds and has limited exposure to equity securities. At March 31, 2004 and December 31, 2003, greater than 99% of the Company's investment portfolio was invested in debt securities. The bond portfolio had an average quality rating of AA at March 31, 2004 and December 31, 2003, as measured by Standard & Poor's Corporation, and the Company held no below investment grade securities. The majority of the bond portfolio was classified as available for sale. The Company had no investment in mortgage loans, non-publicly traded securities, real estate held for investment or financial derivatives.

The Company's cash provided by operations was $10.4 million for the three months ended March 31, 2004, compared to cash used in operations of $3.6 million for the corresponding period in the prior year. During the first quarter of 2004, the Company received a cash payment of $5.9 million resulting from the PBM settlement described above. The remaining improvement in cash flow resulted from expenditures the Company incurred during the first quarter of the prior year for prepaid software maintenance fees, prepaid insurance and higher prior year payments of taxes and other operational expenses.

The Company maintains a revolving bank line of credit agreement with a maximum available facility of $50.0 million. At March 31, 2004, the outstanding balance of advances under the credit agreement was $30.2 million. The credit agreement requires a lump-sum payment of the outstanding balance at the end of 2005. The credit agreement contains customary covenants which, among other matters, require the Company to achieve certain minimum financial results, prohibit the Company from paying future cash dividends and restrict or limit the Company's ability to incur additional debt and dispose of assets outside the ordinary course of business. The Company was in compliance with all such covenants at March 31, 2004. The Company's obligations under the credit agreement are guaranteed by its subsidiary, American Medical Security Holdings, Inc. ("AMS

Holdings"), and secured by pledges of stock of AMS Holdings and United Wisconsin Life Insurance Company, the Company's principal insurance subsidiary.



During the first quarter of 2004, the Company continued its investment in an enterprise-wide information technology modernization project. The project involves the purchase of software applications and the utilization of internal and external technology and consulting resources to support most of the Company's major business processes. Management believes this software investment will help support business growth, operational efficiency, service improvements and future administrative cost savings. The design and development of the software applications began during the first quarter of 2003. Certain administrative software applications were implemented during 2003 and the first quarter of 2004, and the remaining implementation is scheduled to be phased in over the next few years. Capital expenditures during the first quarter of 2004, primarily relating to this project, were $1.6 million. Management believes that the Company's existing working capital and operating cash flow will be sufficient to fund the Company's anticipated future capital expenditures related to this project.

In January 2003, the Company's Board of Directors approved a share repurchase program, which provides the Company with the authority to repurchase up to $10.0 million of its outstanding common shares. The plan allows the Company to buy back its shares, from time to time, in open market or privately negotiated transactions, subject to price and market conditions. During 2003, the Company purchased 87,900 shares of its common stock at an average market price of $15.44 per share, and at an aggregate cost of $1.4 million. No share repurchases were made by the Company during the first quarter of 2004. The share repurchase program will continue to be supported through existing funds and future cash flow.

Dividends paid by the insurance subsidiaries to the corporate parent may be limited by state insurance regulations. The insurance regulator in the insurer's state of domicile may disapprove any dividend which, together with other dividends paid by an insurance company in the prior 12 months, exceeds the regulatory maximum, computed as the lesser of 10% of statutory capital and surplus or total statutory net gain from operations as of the end of the preceding calendar year. Based upon the financial statements of the Company's insurance subsidiaries as of December 31, 2003, as filed with the insurance regulators, the amount available for dividend without regulatory approval is $6.3 million until December 2004, when a dividend of $17.3 million can be paid without regulatory approval.

The National Association of Insurance Commissioners has adopted risk-based capital ("RBC") standards for life and health insurers designed to evaluate the adequacy of statutory capital and surplus in relation to various business risks faced by such insurers. The RBC formula is used by state insurance regulators as an early warning tool to identify insurance companies that potentially are inadequately capitalized. At December 31, 2003, each of the Company's insurance subsidiaries had RBC ratios substantially above the levels that would require Company or regulatory action.

The Company does not expect to pay any cash dividends in the foreseeable future and intends to employ its earnings in the continued development of its business. The Company's future dividend policy will depend on its earnings, capital requirements, debt covenant restrictions, financial condition and other factors considered relevant by the Company's Board of Directors.

CAUTIONARY FACTORS

This report and other documents or oral presentations prepared or delivered by and on behalf of the Company contain or may contain "forward-looking statements" within the meaning of the safe harbor provisions of the United States Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements based upon management's expectations at the time such statements are made. The Company undertakes no obligation to publicly update or revise any forward-looking statements, whether as a result of new information, future events or otherwise. Forward-looking statements are subject to risks and uncertainties that could cause the Company's actual results to differ materially from those contemplated in the statements. Readers are cautioned not to place undue reliance on the forward-looking statements. When used in written documents or oral presentations, the terms "anticipate," "believe," "estimate," "expect," "may," "objective," "plan," "possible," "potential," "project," "will" and similar expressions are intended to identify forward-looking statements. In addition to the assumptions and other factors referred to specifically in connection with such statements, factors that could impact the Company's business and financial prospects include, but are not limited to, those discussed below and those discussed from time to time in the Company's various filings with the Securities and Exchange Commission or in other publicly disseminated written documents:



MEDICAL CLAIMS AND HEALTH CARE COSTS. If the Company is unable to accurately estimate medical claims and control health care costs, its results of operations may be materially adversely affected.

The Company estimates the costs of its future medical claims and other expenses using actuarial methods based upon historical data, medical inflation, product mix, seasonality, utilization of health care services and other relevant factors. The Company establishes premiums based on these methods. The premiums the Company charges its customers generally are fixed for one-year periods, and therefore, costs the Company incurs in excess of its medical claim projections generally are not recovered in the contract year through higher premiums. Certain factors may and often do cause actual health care costs to vary from what the Company estimated and reflected in premiums. These factors may include, but not be limited to: (1) an increase in the rates charged by providers of health care services and supplies, including pharmaceuticals; (2) higher than expected use of health care services by members; (3) the occurrence of bioterrorism, catastrophes or epidemics; (4) changes in the demographics of members and medical trends affecting them; and (5) new mandated benefits or other regulatory changes that increase the Company's costs. The occurrence of any of these factors, which are beyond the Company's control, could result in a material adverse effect on its business, financial condition and results of operations.

GOVERNMENT REGULATIONS. The Company conducts business in a heavily regulated industry, and changes in government regulation could increase the costs of compliance or cause the Company to discontinue marketing its products in certain states.

The Company's business is extensively regulated by federal and state authorities. Some of the new federal and state regulations promulgated under the Health Insurance Portability and Accountability Act of 1996, or HIPAA, relating to health care reform require the Company to implement changes in its programs and systems in order to maintain compliance. The Company has incurred significant expenditures as a result of HIPAA regulations and expects to continue to incur expenditures as various regulations become effective.

The Company is subject to periodic changes in state laws and regulations regarding the selection and pricing of risks and other matters. New regulations regarding these issues could increase the Company's costs and decrease its premiums. The Company has in the past decided, and may in the future decide, to discontinue marketing its products in states that have enacted, or are considering, various health care reform regulations that would impair the Company's ability to market its products profitably.

Federal and state legislatures also are considering health care reform measures that may result in higher health insurance costs. Congress is considering legislation allowing small employers to form association health plans, exempt from state insurance regulations, which may impact the risk profile of employers willing to purchase insurance from the Company. In addition, the implementation of "prompt pay" laws, whereby a claim must be paid in a certain number of days regardless of whether it is a valid claim or not, subject to a right of recovery, may have a negative effect on the Company's results of operations.

REGULATORY COMPLIANCE. The Company's failure to comply with new or existing government regulation could subject it to significant fines and penalties.

The Company's efforts to measure, monitor and adjust its business practices to comply with the law are ongoing. Failure to comply with enacted regulations, including the laws mentioned above, could require the Company to pay refunds or result in significant fines, penalties, or the loss of one or more of its licenses. From time to time the Company is subject to inquiries related to its activities and practices in states in which it operates. The Company has been subject to regulatory penalties, assessments and restitution orders in a number of states. Furthermore, federal and state laws and regulations continue to evolve. The costs of compliance may cause the Company to change its operations significantly, or adversely impact the health care provider networks with which the Company does business, which may adversely affect its business and results of operations.

LITIGATION. The Company is subject to class actions and other forms of litigation in the ordinary course of its business, including litigation based on new or evolving legal theories, which could result in significant liabilities and costs.



For example, a Florida Circuit Court has found the Company liable for damages in a class action lawsuit in Florida. The Company believes a trial to determine damages could not be held before the fourth quarter of 2004. Further, the Company is involved in a number of lawsuits in various states that allege misrepresentation by the Company of its renewal rating methodology. For additional information, see Part II, Item 1, "Legal Proceedings."

The nature of the Company's business subjects it to a variety of legal actions and claims relating but not limited to the following: (1) denial of health care benefits; (2) disputes over rating methodology and practices or termination of coverage; (3) disputes with agents over compensation or other matters; (4) disputes related to claim administration errors and failure to disclose network rate discounts and other fee and rebate arrangements; (5) disputes related to managed care or cost containment activities, (6) disputes over co-payment calculations; and (7) customer audits of compliance with the Company's plan obligations.

The Company cannot predict with certainty the outcome of lawsuits against the Company or the potential costs involved.

COMPETITION. Competition in the Company's industry may limit its ability to attract new members or to maintain its existing membership in force.

The Company operates in a highly competitive environment. The Company competes primarily on the basis of price, benefit plan design, strength of provider networks, quality of customer service, reputation and quality of agent relations. The Company competes for members with other health insurance providers and managed care companies, many of whom have larger membership in regional markets and greater financial resources. Consolidations within the industry may also contribute to the competitive environment. The Company cannot provide assurance that it will be able to compete effectively in this industry. As a result, the Company may be unable to attract new members or maintain its existing membership and its revenues may be adversely affected.

BUSINESS GROWTH STRATEGY. The Company's future operating performance is largely dependent on its ability to execute its growth strategy.

The Company has experienced a decline in membership over the last several years as part of its strategy to improve profitability and exit certain markets. The Company's challenge is to increase the number of individuals and small employer groups purchasing its products and services and to retain existing members. Also impacting the Company's growth prospects is the affordability of health insurance premiums as health care costs continue to rise, as well as the downsizing or restrained hiring among small employers as a result of economic uncertainty. If the Company's initiatives are not successful and the Company does not meet its growth goals, the Company's future operating performance may be adversely affected.

INFORMATION SYSTEMS. A failure of the Company's information system could adversely affect its business.

Information processing is critical to the Company's business. The Company depends on its information system for timely and accurate information. The Company's failure to maintain an effective and efficient information system or disruptions in its information system could cause disruptions in its business operations, including any of the following: (1) failure to comply with prompt pay laws; (2) loss of existing members; (3) difficulty in attracting new members; (4) disputes with members, providers and agents; (5) regulatory problems; (6) increases in administrative expenses; and (7) other adverse consequences.

The Company is investing in an enterprise-wide information technology modernization project involving the purchase of software applications to support most of the Company's major processes. The design and development of the software applications began in early 2003, with a phased implementation scheduled over the next few years. Although the Company is taking measures to safeguard against disruptions to its information systems during this process, it cannot provide assurance that disruptions will not occur or that the project will be successfully implemented or implemented on schedule.

INDEPENDENT AGENT RELATIONSHIPS. The Company depends on the services of non-exclusive independent agents and brokers to market its products to potential customers. These agents and brokers frequently market the health insurance products of competitors as well as the Company's products. Most of the Company's contracts with agents and brokers are terminable without cause upon 30-days' notice by either party. The Company faces intense



competition for the services and allegiance of independent agents and brokers. The Company cannot provide assurance that they will continue to market the

Company's products in the future or that they will not refer the Company's members to competitors.

In addition, the Company has a relationship with a general agent who, along with affiliated subagents, generated 9% of the Company's premium revenue as of December 31, 2003. The loss of this relationship could hamper the Company's growth plans and, as a result, adversely affect the Company's future operating performance.

NEGATIVE PUBLICITY. Negative publicity regarding the Company's business practices and about the health insurance industry may harm the Company's business and operating results.

In 2002, the Company was subject to negative national publicity surrounding its MedOne(R) rating practices and related legal matters, which management believes harmed the Company's MedOne(R) new member enrollment during the last half of 2002. The Company changed its rating practices in all MedOne(R) markets effective January 1, 2003. Adverse publicity about the Company's rating practices or other matters in the future may affect sales of the Company's products, which could impede the Company's growth plans.

In addition, the health insurance industry, in general, has received negative publicity and does not have a positive public perception. This publicity and perception may lead to increased legislation, regulation, review of industry practices and private litigation. These factors may adversely affect the Company's ability to market its products and increase the regulatory burdens under which the Company operates, further increasing the costs of doing business and adversely affecting operating results.

INSURANCE RISK MANAGEMENT. If the Company's insurers or reinsurers do not perform their obligations or offer affordable coverage with reasonable deductibles or limits, the Company could experience significant losses.

The Company's risk management program includes several insurance policies it has purchased to cover various property, business and other risks of loss. In addition, the Company carries policies to cover its directors and officers. Many of the carriers marketing these lines of coverage are experiencing unfavorable claims experience and loss of, or increased costs for, their own reinsurance coverage. Several carriers have exited markets and no longer offer certain lines of coverage. Accordingly, there is no assurance that the Company will be able to purchase insurance coverages for its own risk management at affordable premiums or with reasonable deductibles and policy limits.

The Company has entered into and may continue to enter into a variety of reinsurance arrangements under which it cedes business to other insurance companies to mitigate large claims risk. Although reinsurance allows for greater diversification of risk relating to potential losses arising from large claims, the Company remains liable if these other insurance companies fail to perform their obligations. As a result, any failure of an insurance company to perform its obligations under an agreement could expose the Company to significant losses. Also, there is no assurance that the Company will be able to purchase reinsurance.

PERSONNEL. Loss of key personnel and the inability to attract and retain qualified employees could have a material adverse impact on the Company's operations.

The Company is dependent on the continued services of its management team, including its key executives. Loss of such personnel could have a material adverse effect on the Company. Some of the members of the Company's senior management have developed relationships with some of the Company's independent agents and brokers. If the Company is unable to retain these employees, the loss

of their services could adversely impact the Company's ability to maintain relations with certain independent agents and brokers who market the Company's products. Additionally, the Company needs qualified managers and skilled employees with insurance industry experience to operate its businesses successfully. From time to time there may be shortages of skilled labor that may make it more difficult and expensive for the Company to attract and retain qualified employees. If the Company is unable to attract and retain qualified individuals or its costs to do so increase significantly, its operations could be materially adversely affected.

PROVIDER NETWORK RELATIONSHIPS. The Company's inability to enter into or maintain satisfactory relationships with provider networks could harm profitability.



The Company's profitability could be adversely impacted by its inability to contract on favorable terms with networks of hospitals, physicians, dentists, pharmacies and other health care providers. The failure to secure cost-effective health care provider network contracts may result in a loss of membership or higher medical costs. In addition, the inability to contract with provider networks, the inability to terminate contracts with existing provider networks and enter into arrangements with new provider networks to serve the same market, and/or the inability of providers to provide adequate care, could adversely affect the Company's results of operations.

A.M. BEST INSURANCE RATING. If the Company's insurance subsidiaries are not able to maintain their current rating by A.M. Best Company, the Company's results of operations could be materially adversely affected.

The Company's insurance subsidiaries are assigned a rating by A.M. Best Company, a nationally recognized rating agency. The rating reflects A.M. Best Company's opinion of the insurance subsidiaries' financial strength, operating results and ability to meet their ongoing obligations. Decreases in operating performance and other financial measures may result in a downward adjustment of A.M. Best Company's rating of the insurance subsidiaries. In addition, other factors beyond the Company's control such as general downward economic cycles and changes implemented by the rating agencies, including changes in the criteria for the underwriting or the capital adequacy model, may result in a decrease in the rating. A downward adjustment in A.M. Best's rating of the Company's insurance subsidiaries could cause the Company's agents or potential customers to look at the Company with less favor, which could have a material adverse effect on the Company's results of operations.

REGULATION LIMITING TRANSFER OF FUNDS. Regulations governing the Company's insurance subsidiaries could affect its ability to satisfy its obligations to creditors as they become due, including obligations under the Company's credit facility.

The Company's insurance subsidiaries are subject to regulations that limit their ability to transfer funds to the Company. If the Company is unable to obtain funds from its insurance subsidiaries, it will experience reduced cash flow, which could affect the Company's ability to pay its obligations to creditors as they become due. The Company will be required to make a lump-sum payment of the outstanding balance under its credit facility at the end of 2005. The Company's outstanding balance at March 31, 2004 was $30.2 million. If the Company's insurance subsidiaries are unable to provide these funds, the Company could default on its obligations under the credit facility.

CAPITAL AND SURPLUS REQUIREMENTS. If the Company's regulated insurance

subsidiaries are not able to comply with state capital standards, state regulators may require the Company to take certain actions that could have a material adverse effect on its results of operations and financial condition.

State regulations govern the amount of capital required to be retained in the Company's regulated insurance subsidiaries and the ability of those regulated subsidiaries to pay dividends. Those state regulations include the requirement to maintain minimum levels of statutory capital and surplus, including meeting the requirements of the risk-based capital standards promulgated by the National Association of Insurance Commissioners. State regulators have broad authority to take certain actions in the event those capital requirements are not met. Those actions could significantly impact the way the Company conducts its business, reduce its ability to access capital from the operations of its regulated insurance subsidiaries and have a material adverse effect on its results of operations and financial condition. Any new minimum capital requirements adopted in the future through state regulation may increase the Company's capital requirements.

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

The Company's market risk has not substantially changed from the year ended December 31, 2003.

ITEM 4. CONTROLS AND PROCEDURES

The Company's management, with the participation of the Company's Chief Executive Officer and Chief Financial Officer, has evaluated the effectiveness of the Company's disclosure controls and procedures as of March 31, 2004. Based on that evaluation, the Company's Chief Executive Officer and Chief Financial Officer concluded that the Company's disclosure controls and procedures were effective as of March 31, 2004. There were no changes in the Company's internal control over financial reporting during the first quarter of 2004 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.



PART II OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

The following report of recent developments in previously reported legal proceedings should be read in conjunction with Item 3, Legal Proceedings, in the Company's annual report on Form 10-K for the fiscal year ended December 31, 2003.

A class action lawsuit was filed against two of the Company's wholly owned subsidiaries, American Medical Security, Inc. ("AMS") and United Wisconsin Life Insurance Company ("UWLIC") in the Circuit Court for Palm Beach County, Florida, by Evelyn Addison and others in February 2002 alleging that the Company failed to follow Florida law when in 1998 it discontinued writing certain health insurance policies and offered new policies to insureds. Plaintiffs claim that the Company wrongfully terminated coverage, improperly notified insureds of conversion rights and charged improper premiums for new coverage. Plaintiffs also allege that UWLIC's renewal rating methodology violated Florida law. In a judgment entered April 24, 2002, the Circuit Court Judge in the class action lawsuit found, among other things, that the policy issued by the Company outside Florida was not exempt from any Florida rating laws and ordered that the question of damages be tried before a jury at a later date. The Company believes a trial could not be held before the fourth quarter of 2004. The Company

believes its practices were in full compliance with Florida law and is vigorously defending itself in this lawsuit.

On March 10, 2004, AMS and UWLIC entered into a settlement agreement to certify and settle a class action lawsuit, Gadson vs. AMS, et al. ("Gadson"), pending in the Circuit Court of Montgomery County, Alabama. The lawsuit was filed in 2001 and involves issues relating to the rating methodology formerly used by the Company for group health benefit plans marketed to individuals in Alabama and Georgia. The settlement has received preliminary approval of the Court. If the settlement receives final approval, all claims of participating class members would be dismissed in exchange for the settlement consideration. The Company believes it is adequately reserved for the cost of the settlement, including related attorneys' fees. It also believes a portion of the cost of settlement should be covered by insurance. Any potential insurance recovery is not reflected as an asset on the Company's balance sheet. The Company expects final approval of the settlement by the Circuit Court in September 2004.

The Company's subsidiaries, AMS and UWLIC, are defendants in a number of lawsuits in various states, primarily Alabama, alleging misrepresentation of the rating methodology used by the Company with respect to certain MedOne(R) products purchased by the plaintiffs. These lawsuits commonly seek unspecified damages for misrepresentation and emotional distress in addition to punitive damages. Some of these cases involve multiple plaintiffs. The cases are in various stages of litigation. The Company believes that these lawsuits are unfounded because the Company properly disclosed the nature of the products sold. The Company also believes the subject matter of the lawsuits falls under the primary jurisdiction of state insurance departments. The Company is vigorously defending itself in these actions. If the class action settlement in Gadson receives final approval, future lawsuits of this nature should be barred in Alabama and Georgia, except with respect to lawsuits brought by persons who opt out of the class settlement.

The Company is involved in various other legal and regulatory actions occurring in the normal course of business. Based on current information, including consultation with outside counsel, management believes any ultimate liability in excess of amounts reserved that may arise from the above-mentioned and all other legal and regulatory actions would not have a material adverse effect on the Company's consolidated financial position or results of operations. However, management's evaluation of the likely impact of these actions could change in the future and an unfavorable outcome could have a material adverse effect on the Company's consolidated financial position, results of operations or cash flow of a future period.



ITEM 6. EXHIBITS AND REPORTS ON FORM 8-K

(a) EXHIBITS

See the Exhibit Index following the signature page of this report, which is incorporated herein by reference.

(b) REPORTS ON FORM 8-K

The Company filed or submitted the following reports on Form 8-K during the first quarter of 2004:

- A Form 8-K dated February 2, 2004, was submitted on February 2, 2004, to furnish the Company's earnings release for the quarter and year ended December 31, 2003.

- A Form 8-K dated March 23, 2004, was filed on March 24, 2004, to report the Company's settlement of a dispute involving its former pharmacy benefits manager.

- A Form 8-K dated March 25, 2004, was filed on March 25, 2004, to report that the Company will begin distributing certain products in Kentucky.

After the end of the quarter, the Company submitted the following reports on Form 8-K:

- A Form 8-K dated May 4, 2004, was submitted on May 4, 2004, to furnish the Company's earnings release for the quarter ended March 31, 2004.



SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

DATE: May 6, 2004

AMERICAN MEDICAL SECURITY GROUP, INC.

/s/ John R. Lombardi
John R. Lombardi
Executive Vice President, Chief Financial Officer and Treasurer
(Principal Financial Officer and Chief Accounting Officer and duly authorized to sign on behalf of the Registrant)



AMERICAN MEDICAL SECURITY GROUP, INC.
(the "Registrant")
(Commission File No. 1-13154)

EXHIBIT INDEX
TO
FORM 10-Q QUARTERLY REPORT
for quarter ended March 31, 2004

| EXHIBIT NUMBER | DESCRIPTION | INCORPORATED HEREIN BY REFERENCE TO | FILED HEREWITH |
|---|---|---|---|
| 31.1 | Certification of Chief Executive Officer Pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Securities Exchange Act | | X |

| | | |
|---|---|---|
| | of 1934, as amended | |
| 31.2 | Certification of Chief Financial Officer Pursuant to Rule 13a-14(a) or Rule 15d-14(a) of the Securities Exchange Act of 1934, as amended | X |
| 32 | Certification of Chief Executive Officer and Chief Financial Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 | X |