

HealthMarkets, Inc.
Form 10-K
April 02, 2007

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

Form 10-K

- þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES
EXCHANGE ACT OF 1934
For the Fiscal Year Ended December 31, 2006.**
- o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES
EXCHANGE ACT OF 1934 [NO FEE REQUIRED]
For the transition period from to**

Commission file no. 001-14953

HealthMarkets, Inc.

(Exact name of registrant as specified in its charter)

Delaware

*(State or other jurisdiction of
Incorporation or organization)*

9151 Boulevard 26

North Richland Hills, Texas

(Address of principal executive offices)

75-2044750

*(IRS Employer
Identification No.)*

76180

(Zip Code)

Registrant's telephone number, including area code:

(817) 255-5200

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

None

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

Class A-2 common stock

(Title of class)

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

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

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 No

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

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

Large accelerated filer Accelerated filer Non-accelerated filer

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

Effective April 5, 2006, all of the registrant's Class A-1 common stock (representing approximately 88.62% of its common equity at March 10, 2007) is owned by three private investor groups and members of management. The registrant's Class A-2 common stock is owned by its independent insurance agents and is subject to transfer restrictions. Neither the Class-A-1 common stock nor the Class A-2 common stock is listed or traded on any exchange or market. Accordingly, as of June 30, 2006, the last business day of the registrant's most recently completed second fiscal quarter, the aggregate market value of shares of Class A-1 and Class A-2 common stock held by non-affiliates was \$-0-. As of March 10, 2007, there were 26,892,160.2016 outstanding shares of Class A-1 common stock and 3,454,835.0000 outstanding shares of Class A-2 common stock.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the annual information statement for the annual meeting of stockholders are incorporated by reference into Part III.

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PART I

Item 1. Business

Introduction

HealthMarkets, Inc. and its subsidiaries are collectively referred to throughout this Annual Report on Form 10-K as the *Company* or *HealthMarkets* and may also be referred to as *we*, *us* or *our*.

We offer insurance (primarily health and life) to niche consumer and institutional markets. Through our subsidiaries we issue primarily health insurance policies, covering individuals and families, to the self-employed, association groups and small businesses.

HealthMarkets is a holding company, and we conduct our insurance businesses through our indirect, wholly-owned insurance company subsidiaries, The MEGA Life and Health Insurance Company (*MEGA*), Mid-West National Life Insurance Company of Tennessee (*Mid-West*) and The Chesapeake Life Insurance Company (*Chesapeake*). MEGA is an insurance company domiciled in Oklahoma and is licensed to issue health, life and annuity insurance policies in all states except New York. Mid-West is an insurance company domiciled in Texas and is licensed to issue health, life and annuity insurance policies in Puerto Rico and all states except Maine, New Hampshire, New York, and Vermont. Chesapeake is an insurance company domiciled in Oklahoma and is licensed to issue health and life insurance policies in all states except New Jersey, New York and Vermont.

Through our Self-Employed Agency Division, we offer a broad range of health insurance products for self-employed individuals and individuals who work for small businesses. Our basic hospital-medical and catastrophic hospital expense plans are designed to accommodate individual needs and include traditional fee-for-service indemnity plans and preferred provider organization (*PPO*) plans, as well as other supplemental types of coverage. Commencing in 2006, we began to offer on a selective state-by-state basis a new suite of health insurance products to the self-employed and individual market, including a basic medical-surgical expense plan, catastrophic expense PPO plans and catastrophic expense consumer guided health plans.

We market these products to the self-employed and individual markets through independent contractor agents associated with UGA-Association Field Services (the principal marketing division of The MEGA Life and Health Insurance Company) and Cornerstone America (the principal marketing division of Mid-West National Life Insurance Company of Tennessee), which are our dedicated agency sales forces that primarily sell the Company's products. We believe that we have the largest direct selling organization in the health insurance field, with approximately 2,100 independent writing agents per week in the field selling health insurance to the self employed market in 44 states.

Through our Life Insurance Division, we also issue universal life, whole life and term life insurance products to individuals in four markets that we believe are underserved: the self-employed market, the middle income market, the Hispanic market and the senior market. We distribute these products directly to individual customers through our UGA and Cornerstone agents and other independent agents contracted through two key unaffiliated marketing companies. These two marketing companies, in turn, distribute our life products through managing general agent (MGA) networks.

ZON Re USA LLC (an 82.5%-owned subsidiary) underwrites, administers and issues accidental death, accidental death and dismemberment (AD&D), accident medical, and accident disability insurance products, both on a primary and on a reinsurance basis. We distribute these products through professional reinsurance intermediaries and a network of independent commercial insurance agents, brokers and third party administrators (*TPAs*).

On April 5, 2006, we completed a merger (the Merger) providing for the acquisition of the Company by affiliates of a group of private equity investors, including affiliates of The Blackstone Group, Goldman Sachs Capital Partners and DLJ Merchant Banking Partners (the Private Equity Investors). See Note B of Notes to Consolidated Financial Statements. As a result of the Merger, holders of record on April 5, 2006 of HealthMarkets common shares (other than shares held by certain members of management and shares held through HealthMarkets agent stock accumulation plans) received \$37.00 in cash per share. In the transaction, HealthMarkets public

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shareholders received aggregate consideration of approximately \$1.6 billion, of which approximately \$985.0 million was contributed as equity by the private equity investors. The balance of the Merger consideration was financed with the proceeds of a \$500.0 million term loan facility extended by a group of banks, the proceeds of \$100.0 million of trust preferred securities issued in a private placement, and Company cash on hand in the amount of approximately \$42.8 million.

Our operating segments for financial reporting purposes include (a) the Insurance segment, which includes the businesses of the Company's Self-Employed Agency (SEA) Division, the Life Insurance Division and Other Insurance, (b) Other Key Factors, which includes investment income not otherwise allocated to the Insurance segment, realized gains and losses, interest expense on corporate debt, general expenses relating to corporate operations, variable stock compensation and other unallocated items, and (c) Disposed Operations, which includes the Company's former Star HRG and former Student Insurance Division (which operations were sold on July 11, 2006 and December 1, 2006, respectively). See Note T of Notes to Consolidated Financial Statements for financial information regarding our segments.

Our principal executive offices are located at 9151 Boulevard 26, North Richland Hills, Texas 76180-5605, and our telephone number is (817) 255-5200.

As of March 30, 2007, approximately 88% of our common equity securities are held by affiliates of three private equity investors, and as such, we remain subject to the periodic reporting and other requirements of the Securities Exchange Act of 1934, as amended. Our periodic SEC filings, including our annual reports on Form 10-K, quarterly reports on Form 10-Q, Current Reports on Form 8-K, and if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934 are available through our web site at www.healthmarkets.com free of charge as soon as reasonably practicable after such material is electronically filed with, or furnished to, the SEC.

Recent Developments – Sales of Former Student Insurance Division and Star HRG Division

Our results of operations in 2006 reflected significant gains realized from the sales of our former Star HRG operations and Student Insurance Division, completed on July 11, 2006 and December 1, 2006, respectively. In particular, in 2006 we recognized pre-tax gains in the amount of approximately \$101.5 million and \$100.2 million in connection with the sale of Star HRG Division and the Student Insurance Division, respectively.

See Management's Discussion and Analysis of Financial Condition and Results of Operations and Note C of Notes to Consolidated Financial Statements for a further discussion of the terms of the sales of the Star HRG Division and the Student Insurance Division.

Ratings

Our principal insurance subsidiaries are rated by A.M. Best, Fitch and Standard & Poor's (S&P). Set forth below are financial strength ratings of the principal insurance subsidiaries.

	A.M. Best	Fitch	S&P
MEGA	A– (Excellent)	A– (Strong)	BBB+ (Good)
Mid-West	A– (Excellent)	A– (Strong)	BBB+ (Good)
Chesapeake	A– (Excellent)	BBB+ (Good)	BBB (Good)

In the table above, the A.M. Best's ratings carry a negative outlook and the Fitch and S&P ratings carry a stable outlook.

In evaluating a company, independent rating agencies review such factors as the company's capital adequacy, profitability, leverage and liquidity, book of business, quality and estimated market value of assets, adequacy of policy liabilities, experience and competency of management, and operating profile. A.M. Best's ratings currently range from A++ (Superior) to F (Liquidation). A.M. Best's ratings are based upon factors relevant to policyholders, agents, insurance brokers and intermediaries and are not directed to the protection of investors. Fitch's ratings provide an overall assessment of an insurance company's financial strength and security, and the ratings are used to support insurance carrier selection and placement decisions. Fitch's ratings range from AAA

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(Exceptionally Strong) to C (Very Weak). S&P's financial strength rating is a current opinion of the financial security characteristics of an insurance organization with respect to its ability to pay under its insurance policies and contracts in accordance with their terms. Standard & Poor's financial strength ratings range from AAA (Extremely Strong) to CC (Extremely Weak).

A.M. Best has assigned to HealthMarkets, Inc. an issuer credit rating of bbb- (Good) with a watch negative outlook. A.M. Best's issuer credit rating is a current opinion of an obligor's ability to meet its senior obligations. A.M. Best's issuer credit ratings range from aaa (Exceptional) to d (In Default).

Fitch has assigned to HealthMarkets, Inc. a long term issuer default rating of BBB (Good) with a stable outlook. Fitch's long term issuer default rating is a current opinion of an obligor's ability to meet all of its most senior financial obligations on a timely basis over the term of the obligation. Fitch's long term issuer default ratings range from AAA (Exceptionally Strong) to D (Default).

Standard & Poor's Rating Services has assigned to HealthMarkets, Inc. a counterparty credit rating of BB+ (Less Vulnerable) with a stable outlook. S&P's counterparty credit rating is a current opinion of an obligor's overall financial capacity to pay its financial obligations. Standard & Poor's counterparty credit ratings range from AAA (Extremely Strong) to D (Default).

Insurance Segment

Self-Employed Agency Division

Through our Self-Employed Agency Division, we offer a broad range of health insurance products for the individual and self-employed market (*i.e.*, self-employed individuals and individuals who work for small businesses) and products for the small (2-15 members) employer group market. The Self-Employed Agency Division generated revenues of \$1.462 billion, \$1.526 billion and \$1.496 billion, representing 68%, 72% and 72% of our total revenue in 2006, 2005 and 2004, respectively. We currently have in force approximately 350,000 health insurance policies issued or coinsured by the Company.

We offer a broad range of health insurance products for self-employed individuals and individuals who work for small businesses:

Our Traditional Health Products

Our traditional health insurance plan offerings for the self-employed market have included the following:

Our Basic Hospital-Medical Expense Plan has a \$1.0 million lifetime maximum benefit for all injuries and sicknesses and \$500,000 lifetime maximum benefit for each injury or sickness. Covered expenses are subject to a deductible. Covered hospital room and board charges are reimbursed at 100% up to a pre-selected daily maximum. Covered expenses for inpatient hospital miscellaneous charges, same-day surgery facility, surgery, assistant surgeon, anesthesia, second surgical opinion, doctor visits, and ambulance services are reimbursed at 80% to 100% up to a scheduled maximum. This type of health insurance policy is of a scheduled benefit nature, and, as such, provides benefits equal to the lesser of the actual cost incurred for covered expenses or the maximum benefit stated in the policy. These limitations allow for more certainty in predicting future claims experience, and, as a result, we expect that future premium increases for this policy will be lower than future premium increases on our catastrophic policy.

Our Preferred Provider Plan incorporates features of a preferred provider organization, which are designed to control healthcare costs through negotiating discounts with a PPO network. Benefits are structured to encourage the use of providers with which we have negotiated lower fees for the services to be provided. The savings from these negotiated fees reduce the costs to the individual policyholders. The policies that provide for the use of a PPO impose greater policyholder cost sharing if the policyholder uses providers outside of the PPO network.

Our Catastrophic Hospital Expense Plan provides a \$2.0 million lifetime maximum for all injuries and sicknesses and a lifetime maximum benefit for each injury or sickness ranging from \$500,000 to \$1.0 million. Covered expenses are subject to a deductible and are then reimbursed at a benefit payment rate ranging

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from 50% to 100% as determined by the policy. After a pre-selected dollar amount of covered expenses has been reached, the remaining expenses are reimbursed at 100% for the remainder of the period of confinement per calendar year. The benefits for this plan tend to increase as hospital care expenses increase and, as a result, premiums on these policies are subject to increase as overall hospital care expenses rise.

Each of our traditional health insurance products is available with a menu of various options (including various deductible levels, coinsurance percentages and limited riders that cover particular events such as outpatient accidents, and doctors visits), enabling the insurance product to be tailored to meet the insurance needs and the budgetary constraints of the policyholder. We offer as an optional benefit the Accumulated Covered Expense (ACE) rider that provides for catastrophic coverage on our Scheduled/Basic plans for covered expenses under the contract that generally exceed \$100,000 or, in certain cases, \$75,000. The rider pays benefits at 100% after the stop loss amount is reached, up to the aggregate maximum amount of the contract for expenses covered by the rider.

Our CareOne Product Suite

In the first quarter of 2006, the Company introduced and began offering its new CareOne product portfolio to the self-employed and individual market. As CareOne products are approved in various states, the Company intends over time to replace its traditional health insurance product offerings with its new CareOne products.

The new CareOne product portfolio includes a new Basic Medical/Surgical Expense Plan, two versions of a Catastrophic Expense PPO Plan and two versions of a Catastrophic Expense Consumer Guided Health Plan:

The CareOne Value Plan is a new Basic Medical/Surgical Expense Plan with a \$2.0 million lifetime benefit for all injuries and sicknesses and \$500,000 lifetime maximum benefit for each injury or sickness. Covered expenses are subject to a deductible and coinsurance. Covered inpatient and outpatient hospital charges are reimbursed up to pre-selected per-injury or sickness maximums. Surgeon, assistant surgeon, anesthesia, second surgical opinion, and ambulance services are also reimbursed to a scheduled maximum. Additional benefits are available through riders and include prescription drugs, emergency services and wellness care, among others. This type of health insurance policy is of a scheduled benefit nature, and as such, provides benefits equal to the lesser of the actual cost incurred for covered expenses or the maximum benefit stated in the policy. These limitations allow for more certainty in predicting future claims experience, and, as a result, we expect that future premium increases for this policy will be less than future premium increases on our more comprehensive policies. As of January 1, 2007, the CareOne Value Plan had been approved for issuance in 30 states.

The CareOne Plan is a new Catastrophic Expense PPO Plan and provides a \$5.0 million lifetime maximum for all injuries and sicknesses and a maximum benefit for each injury or sickness of \$1.0 million. This plan incorporates features of a preferred provider organization, which are designed to control healthcare costs through negotiating provider discounts with a PPO network. Benefits are structured to encourage the use of providers with which we have negotiated lower fees for the services to be provided. This plan imposes greater policyholder cost sharing if the policyholder uses providers outside of the PPO network. Covered expenses are subject to a deductible and are then reimbursed at a benefit payment rate ranging from 70% to 80% as determined by the policy. After a pre-selected dollar amount of covered expenses has been reached, the remaining expenses are reimbursed at 100% for the remainder of the period of confinement per calendar year. As a premium and cost savings measure, this new plan limits payment for diagnostic services (e.g. X-rays and laboratory tests) to those diagnostic services that take place within 21 days of, and are directly related to, a hospitalization or outpatient surgery. The benefits for this plan tend to increase as hospital care expenses increase and, as a result, premiums on these policies are subject to an increase as overall hospital care expenses rise. As of January 1, 2007, the CareOne Plan had been approved for issuance in 32 states.

The CareOne Plus Plan is a second new Catastrophic Expense PPO Plan and provides a \$5.0 million lifetime maximum for all injuries and sicknesses and a maximum benefit for each injury or sickness of \$1.0 million. This plan also incorporates features of a preferred provider organization, which are designed to control healthcare costs through negotiating provider discounts with a PPO network. Benefits are structured to encourage the use of providers with which we have negotiated lower fees for the services to be provided.

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This plan imposes greater policyholder cost sharing if the policyholder uses providers outside of the PPO network. Covered expenses are subject to a deductible and are then reimbursed at a benefit payment rate ranging from 70% to 80% as determined by the policy. After a pre-selected dollar amount of covered expenses has been reached, the remaining expenses are reimbursed at 100% for the remainder of the period of confinement per calendar year. The benefits for this plan tend to increase as hospital care expenses increase and, as a result, premium on these policies are subject to an increase as overall hospital care expenses rise. As of January 1, 2007, the CareOne Plus Plan had been approved for issuance in 32 states.

The CareOne Select Plan is a new Catastrophic Expense Consumer Guided Health Plan and provides a \$5.0 million lifetime maximum for all injuries and sicknesses and a maximum benefit for each injury or sickness of \$1.0 million. This plan incorporates features of a consumer guided health plan, including information tools available on the internet or through customer service support via the telephone that provide customers with access to information about their benefits and healthcare provider cost and quality. Covered expenses are subject to a Maximum Allowable Charge (MAC), which is the maximum fee payable under the policy for a particular healthcare service. As a premium and cost savings measure, this new plan limits payment for diagnostic services (e.g., X-rays and laboratory tests) to those diagnostic services that take place within 21 days of, and are directly related to, a hospitalization or outpatient surgery. The MAC allows for more certainty in predicting future claims experience, and, as a result, we expect that future premium increases for this policy will be less than future premium increases on our catastrophic PPO policies. As of January 1, 2007, the CareOne Select Plan had been approved for issuance in 31 states.

The CareOne Select Plus Plan is a second new Catastrophic Expense Consumer Guided Health Plan and provides a \$5.0 million lifetime maximum for all injuries and sicknesses and a maximum benefit for each injury or sickness of \$1.0 million. This plan also incorporates features of a consumer guided health plan, including information tools available on the internet or through customer service support via the telephone that provide customers with access to information about their benefits and healthcare provider cost and quality. Covered expenses are subject to a MAC. The MAC allows for more certainty in predicting future claims experience, and, as a result, we expect that future premium increases for this policy will be less than future premium increases on our catastrophic PPO policies. As of January 1, 2007, the CareOne Select Plus Plan had been approved for issuance in 31 states.

These products are issued and sold by our subsidiaries, MEGA and Mid-West, and are distributed by independent agents associated with MEGA's UGA Association Field Services and Mid-West's Cornerstone America marketing divisions.

Consumer Guided Health Plan Products

In the first quarter of 2005, we began to offer on a selective state-by-state basis a new suite of consumer guided health plans for the individual market. The Company's consumer guided health plans incorporate features that enable consumers to assume a greater role in making healthcare decisions. Information is published on the internet and is available through customer support via the telephone to assist our customers in obtaining access to information about their benefits and healthcare provider cost and quality. The Company's initial consumer guided health plan offerings called the Consumer Preference Plan and the Smart Consumer Plan were available in various states during 2005 and 2006, but are no longer available for purchase. These products were issued and sold by our subsidiary, MEGA, and were distributed by independent agents associated with MEGA's UGA-Association Field Services marketing division.

2007 New Product Introductions

In the second quarter of 2007, we will introduce a new portfolio of Health Savings Account (HSA) qualified High Deductible Health Plans (HDHPs) to the self-employed market. This new product portfolio will include two new products a PPO-based HSA-qualified product and a Consumer Guided Health Plan-based HSA-qualified product:

Our new PPO-based HSA-Qualified HDHPs have a \$5.0 million lifetime maximum benefit for all injuries and sicknesses and a maximum benefit per year of \$1.0 million. This plan incorporates features of a

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preferred provider organization, which are designed to control healthcare costs through negotiating provider discounts with a PPO network. Benefits are structured to encourage the use of providers with which we have negotiated lower fees for the services to be provided. Covered expenses are subject to a deductible and are then reimbursed at a benefit payment rate ranging from 70% to 100% as determined by the policy. After a pre-selected dollar amount of covered expenses has been reached, the remaining expenses are reimbursed at 100% for the remainder of the calendar year. As an optional premium and cost savings measure, this plan can limit payment for diagnostic services (e.g. X-rays and laboratory tests) to those diagnostic services that take place within 21 days of, and are directly related to, a hospitalization or outpatient surgery. The benefits for this plan tend to increase as hospital care expenses increase and, as a result, premiums on these policies are subject to increase as overall hospital care expenses rise.

Our new Consumer Guided Health Plan-based HSA-Qualified HDHPs have a \$5.0 million lifetime maximum benefit for all injuries and sicknesses and a maximum benefit per year of \$1.0 million. This plan incorporates features of a consumer guided health plan, including information tools available on the internet or through customer service support via the telephone that provide customers with access to information about their benefits and healthcare provider cost and quality. Covered expenses are subject to a MAC, which is the maximum fee payable under the policy for a particular healthcare service. Covered expenses are subject to a deductible and are then reimbursed at a benefit payment rate ranging from 70% to 100% as determined by the policy. After a pre-selected dollar amount of covered expenses has been reached, the remaining expenses are reimbursed at 100% for the remainder of the calendar year. As an optional premium and cost savings measure, this plan can limit payment for diagnostic services (e.g. X-rays and laboratory tests) to those diagnostic services that take place within 21 days of, and are directly related to, a hospitalization or outpatient surgery. The MAC allows for more certainty in predicting future claims experience, and, as a result, we expect that future premium increases for this policy will be lower than future premium increases on our new PPO-based HSA-qualified product.

Subject to receipt of applicable regulatory approvals, the Company anticipates that these products will be issued and sold by our subsidiaries, MEGA and Mid-West, and will be distributed by independent agents associated with MEGA's UGA Association Field Services and Mid-West's Cornerstone America marketing divisions.

The Company evaluates new product offerings on an ongoing basis. In the future, we may offer new product lines, including but not limited to product lines focused on markets not traditionally served by the Company.

Ancillary Products

We have also developed and offer new ancillary product lines that provide protection against short-term disability, as well as a combination product that provides benefits for life, disability and critical illness. These products have been designed to further protect against risks to which our core customer is typically exposed.

Third Party Product Initiatives

During 2006, our subsidiaries, MEGA and Mid-West, entered into agreements to distribute health insurance products underwritten by other third-party insurance companies. The products sold under these arrangements focus on markets not traditionally served by the Company, including seniors and high risk customers. These products are distributed by independent insurance agents associated with MEGA's UGA-Association Field Services and Mid-West's Cornerstone America marketing divisions. To date, the Company has generated only nominal revenues from such arrangements.

Marketing and Sales

Substantially all of the health insurance products issued by our insurance company subsidiaries are sold through independent contractor agents. We believe that we have the largest direct selling organization in the health insurance field, with approximately 2,100 independent writing agents per week in the field selling health insurance to the individual and self employed market in 44 states.

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Our agents are independent contractors, and all compensation that agents receive from us for the sale of insurance is based upon the agents' levels of sales production. UGA Association Field Services (UGA) and Cornerstone America (Cornerstone) (the principal marketing divisions of MEGA and Mid-West, respectively) are each organized into geographical regions, with each geographical region having a regional director, two additional levels of field leaders and writing agents (*i.e.*, the agents that are not involved in leadership of other agents).

UGA and Cornerstone are each responsible for the recruitment and training of their field leaders and writing agents. UGA and Cornerstone generally seek persons with previous sales experience. The process of recruiting agents is extremely competitive. We believe that the primary factors in successfully recruiting and retaining effective agents and field leaders are our practices regarding advances on commissions, the quality of the sales leads provided to agents, the availability and accessibility of equity ownership plans, the quality of the products offered, proper training, and agent incentives and support. Classroom and field training with respect to product content is required and made available to the agents under the direction of our regulated insurance subsidiaries.

We provide health insurance products to consumers in the individual and self-employed market in 44 states. As is the case with many of our competitors in this market, a substantial portion of our products is issued to members of various independent membership associations that act as the master policyholder for such products. The two principal membership associations in the self-employed market that make available to their members our health insurance products are the National Association for the Self-Employed and the Alliance for Affordable Services. The associations provide their membership access to a number of benefits and products, including health insurance underwritten by us. Subject to applicable state law, individuals generally may not obtain insurance under an association's master policy unless they are also members of the association. The agreements with these associations requiring the associations to continue as the master policyholder for our policies and to make our products available to their respective members are terminable by us and the associations upon not less than one year's advance notice to the other party. While we believe that we are providing association group coverage in full compliance with applicable law, changes in our relationship with the membership associations and/or changes in the laws and regulations governing so-called association group insurance (particularly changes that would subject the issuance of policies to prior premium rate approval and/or require the issuance of policies on a guaranteed issue basis) could have a material adverse impact on our financial condition, results of operations and/or business.

UGA agents and Cornerstone agents also act as field service representatives (FSRs) for the associations. In this capacity the FSRs enroll new association members and provide membership retention services. For such services, we and the FSRs receive compensation. Specialized Association Services, Inc. (a company controlled by the adult children of the late Ronald L. Jensen, the Company's former Chairman) provides administrative and benefit procurement services to the associations. One of our subsidiaries, HealthMarkets Lead Marketing Group Inc. (formerly known as UICI Marketing, Inc.), serves as our direct marketing group and generates new membership sales prospect leads for both UGA and Cornerstone for use by the FSRs (agents). HealthMarkets Lead Marketing Group also provides video and print services to the associations and to Specialized Association Services, Inc. *See* Note O of Notes to Consolidated Financial Statements. In addition to health insurance premiums derived from the sale of health insurance, we receive fee income from the associations, including fees associated with enrollment and member retention services, fees for association membership marketing and administrative services and fees for certain association member benefits.

HealthMarkets Lead Marketing Group, Inc. generates sales prospect leads for UGA and Cornerstone for use by their agents. HealthMarkets Lead Marketing Group administers a call center (located in Oklahoma City, Oklahoma) staffing approximately 80 tele-service representatives. Leads are also obtained from third party data sources. HealthMarkets Lead Marketing Group has developed a marketing pool of approximately fifteen million prospects from various data sources. Prospects initially identified by HealthMarkets Lead Marketing Group that are

self-employed, small business owners or individuals may become a qualified lead by responding through one of HealthMarkets Lead Marketing Group's lead channels and by expressing an interest in learning more about health insurance. We believe that UGA and Cornerstone agents, possessing the qualified leads' contact information, are able to achieve a higher close rate than is the case with unqualified prospects.

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Policy Design and Claims Management

Our health insurance products are principally designed to limit coverages to the occurrence of significant events that require hospitalization. This policy design, which includes high deductibles, reduces the number of covered claims requiring processing, thereby serving as a control on administrative expenses. We seek to price our products in a manner that accurately reflects our underwriting assumptions and targeted margins, and we rely on the marketing capabilities of our dedicated agency sales forces to sell these products at prices consistent with these objectives.

We maintain administrative centers with full underwriting, claims management and administrative capabilities. We believe that by processing our own claims we can better assure that claims are properly processed and can utilize the claims information to periodically modify the benefits and coverages afforded under our policies.

We have also developed an actuarial data warehouse, which is a critical risk management tool that provides our actuaries with rapid access to detailed exposure, claim and premium data. This analysis tool enhances the actuaries ability to design, monitor and adequately price all of the Self-Employed Agency Division's insurance products.

Provider Network Arrangements and Cost Management Measures

The Company makes available to customers access to selected PPO provider networks so that customers may obtain discounts on provider services that would otherwise not be available. Provider networks are made available on a regional basis, based on the coverage and discounts available within a particular geographic region. In situations where a customer does not obtain services from a contracted provider, the Company applies various usual and customary fees, which limit the amount paid to providers within specific geographic areas.

We believe that access to provider network contracts is a critical factor in controlling medical costs, since there is often a significant difference between a network-negotiated rate and the non-discounted rate. To this end, we access networks of hospitals and physicians through a variety of relationships with third party network providers. During 2006, approximately 84% of submitted claims were adjudicated through provider networks. Of the claims adjudicated through provider networks, approximately 79% were submitted through a primary provider network contract and approximately 5% were submitted through a supplemental network utilized if savings are not achieved through the primary network. In addition, we have retained a pharmacy benefits management company that has approximately 61,000 participating pharmacies nationwide. We also utilize co-payments, coinsurance, deductibles and annual limits to manage prescription drug costs.

The Company utilizes other means to control medical costs, including providing customers with access to supplemental network discounts if savings are not obtained through a primary provider network contract and use of pre- and post-payment fee negotiation services and claim editing services.

Products for the Small Employer Group Market

In the first quarter of 2005, we began to offer our Consumer Advantage Plan to small (2-50 members) employer group consumers in selected urban markets in Texas, Georgia and Michigan. At January 1, 2007, the Consumer Advantage Plan had also been approved for issuance in Alabama, Arizona, Arkansas, Illinois, Missouri, Nevada, Ohio and Tennessee. These products are issued and sold by our subsidiary, The MEGA Life and Health Insurance Company, and distributed by independent agents associated with our UGA Association Field Services marketing division.

To date, the Company has generated only nominal revenues from the sale of health insurance products to the small employer group market.

Life Insurance Division

Our Life Insurance Division offers life insurance products to individuals. At December 31, 2006, the Life Insurance Division (which is based in Oklahoma City, Oklahoma) had nearly \$6.9 billion of net life insurance in force and over 296,000 individual policyholders. The Life Insurance Division generated revenues of \$87.8 million,

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\$83.0 million and \$67.6 million (representing 4%, 4% and 3% of our total revenue) in 2006, 2005 and 2004, respectively.

Markets Served

The Life Insurance Division offers its life insurance products to demographically growing market segments that we have identified as underserved, including the self-employed market, the middle-income market, the Hispanic market and the senior market.

Products

The Life Insurance Division's products are tailored to meet the specific needs of customers in each of its targeted markets. We offer universal life insurance and term life insurance products to individuals in the self-employed market. We offer two other universal life insurance products and other term life insurance products to meet the needs of individuals in the middle-income and the Hispanic markets. We also offer whole life insurance products (level, graded and modified) to assist seniors in meeting their needs to cover final expenses.

Distribution

The Life Insurance Division distributes its insurance products primarily through internal and external distribution channels. Commencing in the second quarter of 2002, our UGA and Cornerstone agents began to market our universal life insurance and term life insurance products to individuals in the self-employed market. In 2003, the Life Insurance Division also entered into new marketing relationships with two independent marketing companies to distribute our universal life insurance, term life insurance and whole life insurance products through networks of managing general agents (MGAs). One marketing company offers universal life insurance and term life insurance products to middle-income buyers and through agencies that specialize in sales to Hispanic buyers. The second marketing company offers our whole life insurance product line exclusively for seniors. At year-end 2006, these two marketing organizations had contracted over 13,000 independent agents to distribute our products.

Marketing and Sales

With the help of agents associated with UGA and Cornerstone, the Life Insurance Division seeks to leverage our significant health insurance customer base by positioning itself to offer those customers (self-employed individuals) universal life insurance and term life insurance products designed to fit their changing needs. The two independent marketing companies that we have contracted with offer universal life insurance and term life insurance product lines through their agents to cover the needs of the middle-income market, the Hispanic market and the senior market. The Life Insurance Division has also developed a needs analysis software selling system, *Blueprint for Life*[®]. This selling tool allows the agent to accurately and quickly identify the amount of insurance that should be carried by an individual. We believe that the *Blueprint for Life*[®] provides a much needed and valuable service to the middle-income buyer, who has often been overlooked or underserved by other distributors of life insurance products.

Other Insurance

Through our 82.5%-owned subsidiary, ZON Re USA LLC (*ZON Re*), we underwrite, administer and issue accidental death, accidental death and dismemberment (AD&D), accident medical and accident disability insurance products, both on a primary and on a reinsurance basis. In the year ended December 31, 2006, ZON Re generated revenues of \$35.3 million and operating income of \$5.5 million.

ZON Re underwrites and manages a portfolio of personal accident reinsurance programs on behalf of MEGA for primary life, accident and health and property and casualty insurers that wish to transfer risks associated with certain types of primary personal accident insurance programs. Accident reinsurance provides reimbursement to primary insurance carriers for covered losses resulting from accidental bodily injury or accidental death. For its reinsurance clients, ZON Re targets national, regional and middle market insurers in the United States and Canada. ZON Re distributes accident reinsurance products through a network of professional reinsurance intermediaries. ZON Re underwrites both treaty and facultative accident reinsurance programs, which may be offered on either a

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quota share or excess of loss basis. The Company has determined, as a matter of policy, that MEGA's exposure on any single reinsurance contract issued by it and underwritten by ZON Re will not exceed \$1.0 million per person and \$10.0 million per event.

ZON Re also underwrites and distributes a limited portfolio of primary accident insurance products issued by Chesapeake. These products are designed for direct purchase by banks, associations, employers and affinity groups and are distributed through a national network of independent commercial insurance agents, brokers and third party administrators (TPAs). The Company has determined, as a matter of policy, that Chesapeake's maximum exposure on any single primary insurance contract issued by it and underwritten by ZON Re will not exceed \$1.0 million per person.

Ceded Reinsurance

Our insurance subsidiaries reinsure portions of the coverages provided by their insurance products with other insurance companies on both an excess-of-loss and coinsurance basis. The maximum retention by us on one individual in the case of life insurance is \$200,000 for MEGA, Mid-West and Chesapeake. We use reinsurance for our health insurance business solely for limited purposes. Reinsurance agreements are intended to limit an insurer's maximum loss.

Competition

In each of our lines of business, we compete with other insurance companies or service providers, depending on the line and product, although we have no single competitor who competes against us in all of the business lines in which we operate. With respect to the business of our Self-Employed Agency Division, the market is characterized by many competitors, and our main competitors include health insurance companies, health maintenance organizations and the Blue Cross/Blue Shield plans in the states in which we write business. While we are among the largest competitors in terms of market share in some of our business lines, in some cases there are one or more major market players in a particular line of business.

Competition in our businesses is based on many factors, including quality of service, product features, price, scope of distribution, scale, financial strength ratings and name recognition. We compete, and will continue to compete, for customers and distributors with many insurance companies and other financial services companies. We compete not only for business and individual customers, employer and other group customers, but also for agents and distribution relationships. Some of our competitors may offer a broader array of products than our specific subsidiaries with which they compete in particular markets, may have a greater diversity of distribution resources, may have better brand recognition, may from time to time have more competitive pricing, may have lower cost structures or, with respect to insurers, may have higher financial strength or claims paying ratings. Organizations with sizable market share or provider-owned plans may be able to obtain favorable financial arrangements from healthcare providers that are not available to us. Some may also have greater financial resources with which to compete. In addition, from time to time, companies enter and exit the markets in which we operate, thereby increasing competition at times when there are new entrants. For example, several large insurance companies have recently entered the market for individual health insurance products and/or consumer guided health plans. We may lose business to competitors offering competitive products at lower prices, or for other reasons, which could materially adversely affect our future results of operations and financial condition.

Regulatory and Legislative Matters

Insurance Regulation

State Regulation General

Our insurance subsidiaries are subject to extensive regulation in their states of domicile and the other states in which they do business under statutes that typically delegate broad regulatory, supervisory and administrative powers to insurance departments. The method of regulation varies, but the subject matter of such regulation covers, among other things, the amount of dividends and other distributions that can be paid by the insurance subsidiaries without prior approval or notification; the granting and revoking of licenses to transact business; trade practices,

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including with respect to the protection of consumers; disclosure requirements; privacy standards; minimum loss ratios; premium rate regulation; underwriting standards; approval of policy forms; claims payment; licensing of insurance agents and the regulation of their conduct; the amount and type of investments that the insurance subsidiaries may hold, minimum reserve and surplus requirements; risk-based capital requirements; and compelled participation in, and assessments in connection with, risk sharing pools and guaranty funds. Such regulation is intended to protect policyholders rather than investors.

State regulation of health insurance products varies from state to state, although all states regulate premium rates, policy forms and underwriting and claims practices to one degree or another. Most states have special rules for health insurance sold to individuals and small groups. For example, a number of states have passed or are considering legislation that would limit the differentials in rates that insurers could charge for healthcare coverage between new business and renewal business for small groups with similar demographics. Every state has also adopted legislation that would make health insurance available to all small employer groups by requiring coverage of all employees and their dependents, by limiting the applicability of pre-existing conditions exclusions, by requiring insurers to offer a basic plan exempt from certain benefits as well as a standard plan, or by establishing a mechanism to spread the risk of high risk employees to all small group insurers.

Various states have from time to time proposed and/or enacted changes to the healthcare system that could affect the relationship between health insurers and their customers. For example, on April 12, 2006, Massachusetts enacted healthcare reform legislation intended to provide healthcare coverage to previously uninsured residents of Massachusetts. Effective July 1, 2007, the law requires all residents to obtain minimum levels of health insurance and requires employers with 11 or more full time employees to pay an assessment if they do not offer health insurance to these employees. The law also establishes the Commonwealth Health Insurance Connector (Connector), through which individuals and small businesses may obtain health insurance directly from the Connector. Our insurance subsidiaries, MEGA and Mid-West, submitted bids to sell products through the Connector, but were not among the companies selected to participate in the Connector. We intend to continue selling health insurance in Massachusetts outside the Connector. In addition, various other states are considering the adoption of play or pay laws requiring that employers either offer health insurance or pay a tax to cover the costs of public healthcare insurance. We cannot predict with certainty the effect that the Massachusetts law, or proposed legislation in other states, if adopted, could have on our insurance businesses and operations.

A number of states have enacted other new health insurance legislation over the past several years. These laws, among other things, mandate benefits with respect to certain diseases or medical procedures, require health insurers to offer an independent external review of certain coverage decisions and establish health insurer liability. There has also been an increase in legislation regarding, among other things, prompt payment of claims, privacy of personal health information, health insurer liability, prohibition against insurers including discretionary clauses in their policy forms and relationships between health insurers and providers. We expect that this trend of increased legislation will continue. These laws may have the effect of increasing our costs and expenses.

We provide health insurance products to consumers in the individual and self-employed market in 44 states. As is the case with many of our competitors in this market, a substantial portion of our products is issued to members of various independent membership associations that act as the master policyholder for such products. During 2004, we, and our insurance company subsidiaries, resolved a nationwide class action lawsuit challenging the nature of the relationship between our insurance companies and the membership associations that make available to their members our insurance companies health insurance products. A number of additional lawsuits challenging the nature of the relationship between our insurance companies and such membership associations are ongoing. *See* Note P of Notes to Consolidated Financial Statements. While we believe that we are providing association group coverage in full compliance with applicable law, changes in our relationship with the membership associations and/or changes in the laws and regulations governing association group insurance (particularly changes that would subject the issuance of

policies to prior premium rate approval and/or require the issuance of policies on a guaranteed issue basis) could have a material adverse impact on our financial condition, results of operations and/or business.

Many states have also enacted insurance holding company laws that require registration and periodic reporting by insurance companies controlled by other corporations. Such laws vary from state to state, but typically require

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periodic disclosure concerning the corporation that controls the controlled insurer and prior notice to, or approval by, the applicable regulator of inter-corporate transfers of assets and other transactions (including payments of dividends in excess of specified amounts by the controlled insurer) within the holding company system. Such laws often also require the prior approval for the acquisition of a significant ownership interest (i.e., 10% or more) in the insurance holding company. HealthMarkets (the holding company) and our insurance subsidiaries are subject to such laws, and we believe that we and such subsidiaries are in compliance in all material respects with all applicable insurance holding company laws and regulations.

Under the risk-based capital initiatives adopted in 1992 by the National Association of Insurance Commissioners (NAIC), insurance companies must calculate and report information under a risk-based capital formula. Risk-based capital formulas are intended to evaluate risks associated with asset quality, adverse insurance experience, losses from asset and liability mismatching, and general business hazards. This information is intended to permit regulators to identify and require remedial action for inadequately capitalized insurance companies, but it is not designed to rank adequately capitalized companies. At December 31, 2006, the risk-based capital ratio of each of our domestic insurance subsidiaries significantly exceeded the ratio for which regulatory corrective action would be required.

The states in which our insurance subsidiaries are licensed have the authority to change the minimum mandated statutory loss ratios to which they are subject, the manner in which these ratios are computed and the manner in which compliance with these ratios is measured and enforced. Loss ratios are commonly defined as incurred claims as a percentage of earned premiums. Most states in which our insurance subsidiaries write insurance have adopted the minimum loss ratios recommended by the NAIC, but frequently the loss ratio regulations do not apply to the types of health insurance issued by our subsidiaries. A number of states are considering the adoption of, or have adopted, laws that would mandate minimum statutory loss ratios, or increase existing minimum statutory loss ratios, for the products we offer. For example, on July 1, 2007, California regulations will become effective that will require a minimum medical loss ratio of 70% for health insurance issued after that date, as well as business issued prior to that date if it is subject to a rate revision. We are unable to predict the impact of (i) any changes in the mandatory statutory loss ratios for individual or group policies to which we may become subject, or (ii) any change in the manner in which these minimums are computed or enforced in the future. Such changes could result in a narrowing of profit margins and adversely affect our business and results of operations. We have not been informed by any state that our insurance subsidiaries do not meet mandated minimum ratios, and we believe that we are in compliance with all such minimum ratios. We have filed new products intended to address the California minimum medical loss ratio requirements that will become effective on July 1, 2007. Our ability to offer these products is subject to receipt of applicable regulatory approvals, and there can be no assurance that approvals will be received. In the event that we are not in compliance with minimum statutory loss ratios mandated by regulatory authorities with respect to certain policies, we may be required to reduce or refund premiums, which could have a material adverse effect upon our business and results of operations.

The NAIC and state insurance departments are continually reexamining existing laws and regulations, including those related to reducing the risk of insolvency and related accreditation standards. To date, the increase in solvency-related oversight has not had a significant impact on our insurance business.

State Regulation Financial and Market Conduct Examinations

Our insurance subsidiaries are required to file detailed annual statements with the state insurance regulatory departments and are subject to periodic financial and market conduct examinations by such departments. The most recently completed financial examination of MEGA in Oklahoma (MEGA's domicile state) was completed as of and for the two-year period ended December 31, 2003. The most recently completed financial examination of Mid-West in Tennessee (Mid-West's state of domicile until October 2005) was completed as of and for the three-year period ended December 31, 2003. The most recently completed financial examination of Chesapeake in Oklahoma (Chesapeake's

domicile state) was completed as of and for the three-year period ended December 31, 2003. In the first quarter of 2007, the Oklahoma Department of Insurance commenced financial examinations of MEGA and Chesapeake for the three-year period ended December 31, 2006 and the Texas Department of Insurance (Mid-West's state of domicile since October 2005) commenced a financial examination of Mid-West for the three-year period ended December 31, 2006. The examinations are ongoing.

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State insurance departments have also periodically conducted and continue to conduct market conduct examinations of HealthMarkets' insurance subsidiaries. In March 2005, HealthMarkets received notification that the Market Analysis Working Group of the National Association of Insurance Commissioners had chosen the states of Washington and Alaska to lead a multi-state market conduct examination of HealthMarkets' principal insurance subsidiaries. We believe that approximately 34 states have elected to participate in the examination, which commenced in May 2005 and is ongoing. The examiners have completed the onsite phases of the examination. An exit interview was held on July 17, 2006, in which representatives of the lead states and the Company participated. The Company expects to receive a draft of the examination report in the near future and will respond to the draft report in a timely manner. While we do not currently believe that the multi-state market conduct examination will have a material adverse effect upon our consolidated financial position or results of operations, state insurance regulatory agencies have authority to levy monetary fines and penalties resulting from findings made during the course of such examinations.

In addition to the multi-state market conduct examination, as of December 31, 2006, MEGA, Mid-West and/or Chesapeake were subject to ongoing market conduct examinations and/or open inquiries with respect to marketing practices in 8 states. State insurance regulatory agencies have authority to levy monetary fines and penalties resulting from findings made during the course of such market conduct examinations. Historically, our insurance subsidiaries have from time to time been subject to such fines and penalties, none of which individually or in the aggregate have had a material adverse effect on our results of operations or financial condition.

On December 6, 2006, MEGA, Mid-West and Chesapeake, entered into a settlement agreement with the Massachusetts Division of Insurance (MA DOI) upon the conclusion of a market conduct examination by the MA DOI covering the period January 1, 2002 to December 31, 2004. The examination consisted of a review of the operations of MEGA, Mid-West and Chesapeake for small group health insurance issued to Massachusetts certificate holders during the examination period. The settlement agreement provides, among other things, for changes in certain Company operations and procedures, including those related to claims handling, complaints and grievances, marketing and sales and underwriting. In addition, MEGA, Mid-West and Chesapeake agreed to conduct a claims reassessment process, pursuant to which the companies are contacting Massachusetts claimants and offering to reassess certain denied claims based on specific codes identified by the MA DOI. The reassessment covers claims for the period January 1, 2002 through December 31, 2004, as well as claims on certificates issued through April 30, 2005 or renewed through July 31, 2005 to the date of their first renewal or lapse. The MA DOI will not impose fines or take other action against the Company unless the Company fails to complete the required actions set forth in the settlement agreement or unless additional material information related to the required actions becomes available to the MA DOI. In entering the settlement, the Company did not admit, deny or concede any actual or potential fault, wrongdoing, liability or violation of law. The Company believes that the terms of the settlement will not have a material adverse effect upon the financial condition or results of operations of the Company.

Federal Regulation

In 1945, the U.S. Congress enacted the McCarran-Ferguson Act, which declared the regulation of insurance to be primarily the responsibility of the individual states. Although repeal of McCarran-Ferguson is debated in the U.S. Congress from time to time, the federal government generally does not directly regulate the insurance business. However, federal legislation and administrative policies in several areas, including healthcare, pension regulation, age and sex discrimination, financial services regulation, securities regulation, privacy laws, terrorism and federal taxation, do affect the insurance business.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

As with other lines of insurance, the regulation of health insurance historically has been within the domain of the states. However, HIPAA and the implementing regulations promulgated thereunder by the Department of Health and Human Services impose obligations for issuers of health and dental insurance coverage and health and dental benefit plan sponsors. HIPAA requires certain guaranteed issuance and renewability of health insurance coverage for individuals and small employer groups (generally 50 or fewer employees) and limits exclusions based on pre-existing conditions. Most of the insurance reform provisions of HIPAA became effective for plan years beginning on or after July 1, 1997.

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HIPAA also establishes requirements for maintaining the confidentiality and security of individually identifiable health information and new standards for electronic healthcare transactions. The Department of Health and Human Services promulgated final HIPAA regulations in 2002. The privacy regulations required compliance by April 2003, the electronic transactions regulations by October 2003, and the security regulations by April 2005. As have other entities in the healthcare industry, we have incurred substantial costs in meeting the requirements of these HIPAA regulations and expect to continue to incur costs to maintain compliance. We have worked diligently to comply with these regulations within the time periods required and believe that we have complied.

HIPAA is a far-reaching and complex issue and proper interpretation and practice under the law continue to evolve. Consequently, our efforts to measure, monitor and adjust our business practices to comply with HIPAA are ongoing. Failure to comply could result in regulatory fines and civil lawsuits. Knowing and intentional violations of these rules may also result in federal criminal penalties.

HealthMarkets is continuously reviewing the potential impact of the HIPAA privacy and security regulations on its operations, including its information technology and security systems. There can be no assurance that the restrictions and duties imposed by the final rules on the privacy and security of individually-identifiable health information will not have a material adverse effect on HealthMarkets' business and future results of operations.

USA PATRIOT Act

On October 26, 2001, the International Money Laundering Abatement and Anti-Terrorist Financing Act of 2001 was enacted into law as part of the USA PATRIOT Act. The law requires, among other things, that financial institutions adopt anti-money laundering programs that include policies, procedures and controls to detect and prevent money laundering, designate a compliance officer to oversee the program and provide for employee training, and periodic audits in accordance with regulations proposed by the U.S. Treasury Department. Treasury regulations governing portions of our life insurance business require that we maintain procedures designed to detect and prevent money laundering and terrorist financing. We remain subject to U.S. regulations that prohibit business dealings with entities identified as threats to national security. We have licensed software to enable us to detect and prevent such activities in compliance with existing regulations and we are developing policies and procedures designed to comply with the proposed regulations should they come into effect.

There are significant criminal and civil penalties that can be imposed for violation of Treasury regulations. We believe that the steps we are taking to comply with the current regulations and to prepare for compliance with the proposed regulations should be sufficient to minimize the risks of such penalties.

CAN SPAM Act

From time to time the Company utilizes, either directly or through third party vendors, e-mail to identify prospective sales leads for use by its agents. The federal CAN SPAM Act, which became effective January 1, 2004 and is administered and enforced by the Federal Trade Commission, establishes national standards for sending bulk, unsolicited commercial e-mail. While targeting and prohibiting e-marketers to send unsolicited commercial e-mail with falsified headers, the CAN SPAM Act permits the use of unsolicited commercial e-mail if and as long as the message contains an opt-out mechanism, a functioning return e-mail address, a valid subject line indicating the e-mail is an advertisement and the legitimate physical address of the mailer. While the Company has taken what it believes are reasonable steps to ensure that it, and the various third party vendors with which it does business, are in full compliance with the CAN SPAM Act, failure to comply with the provisions of the CAN SPAM Act could result in regulatory fines and civil lawsuits.

Gramm-Leach-Bliley Act

The Financial Services Modernization Act of 1999 (the so-called Gramm-Leach-Bliley Act, or GLBA) includes several privacy provisions and introduced new controls over the transfer and use of individuals' nonpublic personal data by financial institutions, including insurance companies, insurance agents and brokers and certain other entities licensed by state insurance regulatory authorities.

GLBA provides that there is no federal preemption of a state's insurance related privacy laws if the state law is more stringent than the privacy rules imposed under GLBA. Accordingly, selected state insurance regulators or state

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legislatures have adopted rules that limit the ability of insurance companies, insurance agents and brokers and certain other entities licensed by state insurance regulatory authorities to disclose and use non-public information about consumers to third parties. These limitations require the disclosure by these entities of their privacy policies to consumers and, in some circumstances, will allow consumers to prevent the disclosure or use of certain personal information to an unaffiliated third party. Pursuant to the authority granted under GLBA to state insurance regulatory authorities to regulate the privacy of nonpublic personal information provided to consumers and customers of insurance companies, insurance agents and brokers and certain other entities licensed by state insurance regulatory authorities, the National Association of Insurance Commissioners has promulgated a model regulation called Privacy of Consumer Financial and Health Information Regulation. Some states issued this model regulation before July 1, 2001, while other states must pass certain legislative reforms to implement new state privacy rules pursuant to GLBA. In addition, GLBA requires state insurance regulators to establish standards for administrative, technical and physical safeguards pertaining to customer records and information to (a) ensure their security and confidentiality, (b) protect against anticipated threats and hazards to their security and integrity, and (c) protect against unauthorized access to and use of these records and information. The privacy and security provisions of GLBA have significantly affected how a consumer's nonpublic personal information is transmitted through and used by diversified financial services companies and conveyed to and used by outside vendors and other unaffiliated third parties.

Employee Retirement Income Security Act of 1974

The Employee Retirement Income Security Act of 1974, as amended (ERISA), regulates how goods and services are provided to or through certain types of employer-sponsored health benefit plans. ERISA is a set of laws and regulations subject to periodic interpretation by the United States Department of Labor (DOL) as well as the federal courts. ERISA places controls on how our insurance subsidiaries may do business with employers who sponsor employee health benefit plans. We believe that many of our products are not subject to ERISA because they are offered to and used by individuals, self-employed persons or employers with less than two participants who are employees as of the start of any plan year. However, some of our products or services may be subject to the ERISA regulations. During 2005 and 2006, we received inquiries from the Boston and Dallas offices of the DOL that alleged, among other things, that certain policy forms in use by our insurance subsidiaries are not ERISA compliant. *See* Note P of Notes to Consolidated Financial Statements. The Company disputes many of these allegations and has presented a plan to the DOL to resolve this matter. We believe that resolution of this matter will not have a material adverse effect on the Company's financial condition or results of operations.

Legislative Developments

Legislation has been introduced in the U.S. Congress that would allow state-chartered and regulated insurance companies, such as our insurance subsidiaries, to choose instead to be regulated exclusively by a federal insurance regulator. We do not believe that such legislation will be enacted during the current Congressional term.

Numerous proposals to reform the current healthcare system have been introduced in the U.S. Congress and in various state legislatures. Proposals have included, among other things, modifications to the existing employer-based insurance system, a quasi-regulated system of *managed competition* among health insurers, and a single-payer, public program. Changes in healthcare policy could significantly affect our business. For example, federally mandated, comprehensive major medical insurance, if proposed and implemented, could partially or fully replace some of our current products. Furthermore, legislation has been introduced from time to time in the U.S. Congress that could result in the federal government assuming a more direct role in regulating insurance companies.

There is also legislation pending in the U.S. Congress and in various states designed to provide additional privacy protections to consumer customers of financial institutions. These statutes and similar legislation and regulations in the United States or other jurisdictions could affect our ability to market our products or otherwise limit the nature or

scope of our insurance operations.

The NAIC and individual states have been studying small face amount life insurance in recent years. Some initiatives that have been raised at the NAIC include further disclosure for small face amount policies and restrictions on premium to benefit ratios. The NAIC is also studying other issues such as *suitability* of insurance products for certain customers. This may have an effect on our pre-funded funeral insurance business. Suitability

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requirements such as a customer assets and needs worksheet could extend and complicate the sale of pre-funded funeral insurance products.

We are unable to evaluate new legislation that may be proposed and when or whether any such legislation will be enacted and implemented. However, many of the proposals, if adopted, could have a material adverse effect on our financial condition, cash flows or results of operations, while others, if adopted, could potentially benefit our business.

Employees

We had approximately 1,800 employees at December 31, 2006. We consider our employee relations to be good. Agents associated with MEGA's UGA and Mid-West's Cornerstone field forces are independent contractors and are not employees of the Company.

Executive Officers of the Company

The Chairman of the Company is elected, and all other executive officers listed below are appointed, by the Board of Directors of the Company at its Annual Meeting each year or by the Executive Committee of the Board of Directors to hold office until the next Annual Meeting or until their successors are elected or appointed. None of these officers have family relationships with any other executive officer or director.

Name of Officer	Principal Position	Age	Business Experience During Past Five Years
William J. Gedwed	Director, President and Chief Executive Officer	51	Mr. Gedwed has served as a director of the Company since June 2000 and as the President and Chief Executive Officer of the Company since July 1, 2003. He was named Chairman of the Board in September 2005 and served in such position until April 2006. He has served as a Director and/or executive officer of NMC Holdings, Inc. and/or its subsidiaries since August 1993. Mr. Gedwed currently serves as Chairman and Director of the Company's insurance subsidiaries.
Troy A. McQuagge	President of the Company's Agency Marketing Group	45	Mr. McQuagge served as President of UGA Association Field Services from 1997 until May 2004. Mr. McQuagge was named as President of the Company's Agency Marketing Group in November 2004. Mr. McQuagge has served as Senior Vice President of the Company's insurance subsidiaries since June 2004.
Michael E. Boxer	Executive Vice President and Chief Financial Officer	45	Mr. Boxer joined the Company in September 2006 as Executive Vice President and Chief Financial Officer. He also serves as a Director, Executive Vice President and Chief Financial Officer of the Company's insurance subsidiaries. Prior to joining the Company, Mr. Boxer served as President of The Enterprise Group Ltd., a health care financial advisory firm. Mr. Boxer served as Executive Vice President and Chief Financial Officer of Mariner

Health Care, Inc., a skilled nursing company, from 2003 until its sale in 2004. Prior to Mariner, Mr. Boxer was Senior Vice President and Chief Financial Officer at Watson Pharmaceuticals, Inc.

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Name of Officer	Principal Position	Age	Business Experience During Past Five Years
Michael A. Colliflower	Executive Vice President and General Counsel	52	Mr. Colliflower was named as Executive Vice President and General Counsel effective August 30, 2006. He also served as the Company's Chief Compliance Officer until March 14, 2007. Mr. Colliflower joined HealthMarkets in July 2005 as Senior Vice President and General Counsel-Insurance Operations. He currently serves as a Director, Executive Vice President and General Counsel of the Company's insurance subsidiaries. Prior to joining the Company, Mr. Colliflower served from October 2002 as Senior Vice President and Chief Insurance Counsel for the insurance subsidiaries of Universal American Financial Corp. From August 1996 until March 2002, Mr. Colliflower held various management positions at the Conseco Companies, including Senior Vice President - Legal and Chief Compliance Officer.
Phillip J. Myhra	Executive Vice President Insurance Group	53	Mr. Myhra has served as an executive officer of the Insurance Group since December 1999 and as Executive Vice President - Insurance Group of the Company since February 2001. He serves as a Director, President and Chief Executive Officer of the Company's insurance subsidiaries. Prior to joining the Company, Mr. Myhra served as Senior Vice President of Mutual of Omaha.
James N. Plato	President Life Insurance Division	58	Mr. Plato was appointed President of the Life Insurance Division and has served as a Director and executive officer of the Company's insurance subsidiaries since June 2001. From 2000 to 2001, Mr. Plato served as an executive officer and/or Director of Ilona Financial Group and its subsidiaries.
Asher M. Schoor	Senior Vice President	35	Mr. Schoor has served as a Senior Vice President since May 2006. Prior to joining the Company, Mr. Schoor was a consultant at McKinsey & Company, where he worked from 2001 until 2006.
Nancy G. Coccozza	Executive Vice President	46	Ms. Coccozza joined the Company on March 30, 2007 as Executive Vice President. Prior to joining the Company, Ms. Coccozza served as Senior Vice President - Government Programs for Coventry Health Care from May 2001 until October 2006.

Item 1A. Risk Factors

The following factors could impact the Company's business and financial prospects:

HealthMarkets may lose business to competitors offering competitive products at lower prices.

We compete, and will continue to compete, for customers and distributors with many insurance companies and other financial services companies. We compete not only for business and individual customers, employer and other group customers, but also for agents and distribution relationships. Our competitors may offer a broader array of products than we do, have a greater diversity of distribution resources, have better brand recognition, have more competitive pricing or, have higher financial strength or claims paying ratings. Competitors with sizable market share or provider-owned plans may be able to obtain favorable financial arrangements from healthcare providers that are not available to us.

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Failure to accurately estimate medical claims and healthcare costs may have a significant impact on the Company's business and results of operation.

If we are unable to accurately estimate medical claims and control healthcare costs, our results of operations may be materially and adversely affected. We estimate the cost of future medical claims and other expenses using actuarial methods based upon historical data, medical inflation, product mix, seasonality, utilization of healthcare services and other relevant factors. We establish premiums based on these methods. The premiums we charge our customers generally are fixed for one-year periods, and costs we incur in excess of our medical claim projections generally are not recovered in the contract year through higher premiums.

Failure of our insurance subsidiaries to maintain their current insurance ratings could materially adversely affect HealthMarkets' business and results of operations.

Our principal insurance subsidiaries are currently rated by A.M. Best Company, Fitch and Standard & Poor's. If our insurance subsidiaries are not able to maintain their current rating by A.M. Best Company, Fitch and/or Standard & Poor's, our results of operations could be materially adversely affected. Decreases in operating performance and other financial measures may result in a downward adjustment of the rating of our insurance subsidiaries assigned by A.M. Best Company, Fitch or Standard & Poor's. Other factors beyond our 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 also result in a decrease in the rating. A downward adjustment in rating by A.M. Best Company, Fitch and/or Standard & Poor's of our insurance subsidiaries could have a material adverse effect on our business and results of operations.

Changes in our relationship with membership associations that make available to their members our health insurance products and/or changes in the laws and regulations governing so-called association group insurance could materially adversely affect HealthMarkets' business and results of operations.

As is the case with many of our competitors in the self-employed market, a substantial portion of our health insurance products is issued to members of various independent membership associations that act as the master policyholder for such products. The two principal membership associations in the self-employed market that make available to their members our health insurance products are the National Association for the Self-Employed and the Alliance for Affordable Services. The associations provide their members access to a number of benefits and products, including health insurance underwritten by us. Subject to applicable state law, individuals generally may not obtain insurance under an association's master policy unless they are also members of the association. The agreements with these associations requiring the associations to continue as the master policyholder for our policies and to make our products available to their respective members are terminable by us or the association upon not less than one year's advance notice to the other party.

MEGA's UGA agents and Mid-West's Cornerstone America agents also act as field service representatives (FSRs) for the associations. In this capacity, the FSRs enroll new association members and provide membership retention services. For such services, we and the FSRs receive compensation. Specialized Association Services, Inc. (a company controlled by the adult children of the late Ronald L. Jensen (the Company's former Chairman)) provides administrative and benefit procurement services to the associations. One of our subsidiaries, HealthMarkets Lead Marketing Group, Inc. (formerly known as UICI Marketing, Inc.), serves as our direct marketing group and generates new membership sales prospect leads for both UGA and Cornerstone for use by the FSRs. HealthMarkets Lead Marketing Group also provides video and print services to the associations and to Specialized Association Services, Inc. In addition to health insurance premiums derived from the sale of health insurance, we receive fee income from the associations, including fees associated with enrollment and member retention services, fees for association

membership marketing and administrative services and fees for certain association member benefits.

While we believe that we are providing association group coverage in full compliance with applicable law, changes in our relationship with the membership associations and/or changes in the laws and regulations governing so-called association group insurance, particularly changes that would subject the issuance of policies to prior premium rate approval and/or require the issuance of policies on a guaranteed issue basis, could have a material adverse impact on our financial condition, results of operations and/or business.

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Our domestic insurance subsidiaries are currently the subject of a multi-state market conduct examination, and an adverse finding or outcome from that examination could adversely affect our results of operations and financial condition.

In March 2005, HealthMarkets received notification that the Market Analysis Working Group of the National Association of Insurance Commissioners had chosen the states of Washington and Alaska to lead a multi-state market conduct examination of HealthMarkets' principal insurance subsidiaries, The MEGA Life and Health Insurance Company, Mid-West National Life Insurance Company of Tennessee and The Chesapeake Life Insurance Company. That examination commenced in May 2005 and is ongoing. While we do not currently believe that the multi-state market conduct examination will have a material adverse effect upon our consolidated financial position or results of operations, state insurance regulatory agencies have authority to levy monetary fines and penalties resulting from findings made during the course of such examinations.

Negative publicity regarding our business practices and about the health insurance industry in general may harm our business and adversely affect our results of operations and financial condition.

The health and life insurance industry and related products and services we provide attracts negative publicity from consumer advocate groups and the media. Negative publicity may result in increased regulation and legislative scrutiny of industry practices as well as increased litigation, which may further increase our costs of doing business and adversely affect our profitability by impeding our ability to market our products and services, requiring us to change our products or services or increasing the regulatory burdens under which we operate.

HealthMarkets' failure to secure and enhance cost-effective healthcare provider network contracts may result in a loss of insureds and/or higher medical costs and adversely affect HealthMarkets' results of operations.

Our results of operations and competitive position could be adversely affected by our inability to enter into or maintain satisfactory relationships with networks of hospitals, physicians, dentists, pharmacies and other healthcare providers. The failure to secure cost-effective healthcare provider network contracts may result in a loss of insureds 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 our results of operations.

HealthMarkets' inability to obtain funds from its insurance subsidiaries may cause it to experience reduced cash flow, which could affect the Company's ability to pay its obligations to creditors as they become due.

We are a holding company, and our principal assets are our investments in our separate operating subsidiaries, including our regulated insurance subsidiaries. Our ability to fund our cash requirements is largely dependent upon our ability to access cash from our subsidiaries. Our insurance subsidiaries are subject to regulations that limit their ability to transfer funds to us. If we are unable to obtain funds from our insurance subsidiaries, we will experience reduced cash flow, which could affect our ability to pay our obligations to creditors as they become due.

A failure of our information systems to provide timely and accurate information could adversely affect our business and results of operations.

Information processing is critical to our business, and a failure of our information systems to provide timely and accurate information could adversely affect our business and results of operations. The failure to maintain an effective and efficient information system or disruptions in our information system could cause disruptions in our business

operations, including (a) failure to comply with prompt pay laws; (b) loss of existing insureds; (c) difficulty in attracting new insureds; (d) disputes with insureds, providers and agents; (e) regulatory problems; (f) increases in administrative expenses; and (g) other adverse consequences.

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Changes in government regulation could increase the costs of compliance or cause us to discontinue marketing our products in certain states.

We conduct business in a heavily regulated industry, and changes in government regulation could increase the costs of compliance or cause us to discontinue marketing our products in certain states. Some of the federal and state regulations promulgated under the Health Insurance Portability and Accountability Act of 1996, or HIPAA, relating to healthcare reform have required us to implement changes in our programs and systems in order to maintain compliance. We have incurred significant expenditures as a result of HIPAA regulations and expect to continue to incur expenditures as various regulations become effective.

We may not have enough statutory capital and surplus to continue to write business.

Our continued ability to write business is dependent on maintaining adequate levels of statutory capital and surplus to support the policies we write. Our new business writing typically results in net losses on a statutory basis during the early years of a policy. The resulting reduction in statutory surplus, or surplus strain, limits our ability to seek new business due to statutory restrictions on premium to surplus ratios and statutory surplus requirements. If we cannot generate sufficient statutory surplus to maintain minimum statutory requirements through increased statutory profitability, reinsurance or other capital generating alternatives, we will be limited in our ability to realize additional premium revenue from new business writing, which could have a material adverse effect on our financial condition and results of operations or, in the event that our statutory surplus is not sufficient to meet minimum premium to surplus and risk-based capital ratios in any state, we could be prohibited from writing new policies in such state.

Our reserves for current and future claims may be inadequate and any increase to such reserves could have a material adverse effect on our financial condition and results of operations.

We calculate and maintain reserves for current and future claims using assumptions about numerous variables, including our estimate of the probability of a policyholder making a claim, the severity and duration of such claim, the mortality rate of our policyholders, the persistency or renewal of our policies in force and the amount of interest we expect to earn from the investment of premiums. The adequacy of our reserves depends on the accuracy of our assumptions. We cannot assure you that our actual experience will not differ from the assumptions used in the establishment of reserves. Any variance from these assumptions could have a material adverse effect on our financial condition and/or results of operations.

Litigation may result in financial losses or harm our reputation and may divert management resources.

Current and future litigation may result in financial losses, harm our reputation and require the dedication of significant management resources. We are regularly involved in litigation. The litigation naming us as a defendant ordinarily involves our activities as an insurer. In recent years, many insurance companies, including us, have been named as defendants in class actions relating to market conduct or sales practices.

For our general claim litigation, we maintain reserves based on experience to satisfy judgments and settlements in the normal course. Management expects that the ultimate liability, if any, with respect to general claim litigation, after consideration of the reserves maintained, will not be material to the consolidated financial condition of the Company. Nevertheless, given the inherent unpredictability of litigation, it is possible that an adverse outcome in certain claim litigation involving punitive damages could, from time to time, have a material adverse effect on our consolidated results of operations in a period, depending on the results of our operations for the particular period.

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If we fail to comply with extensive state and federal regulations, we will be subject to penalties, which may include fines and suspension and which may adversely affect our results of operations and financial condition.

We are subject to extensive governmental regulation and supervision. Most insurance regulations are designed to protect the interests of policyholders rather than stockholders and other investors. This regulation, generally administered by a department of insurance in each state in which we do business, relates to, among other things:

approval of policy forms and premium rates;

standards of solvency, including risk-based capital measurements, which are a measure developed by the National Association of Insurance Commissioners and used by state insurance regulators to identify insurance companies that potentially are inadequately capitalized;

licensing of insurers and their agents;

restrictions on the nature, quality and concentration of investments;

restrictions on transactions between insurance companies and their affiliates;

restrictions on the size of risks insurable under a single policy;

requiring deposits for the benefit of policyholders;

requiring certain methods of accounting;

prescribing the form and content of records of financial condition required to be filed; and

requiring reserves for losses and other purposes.

State insurance departments also conduct periodic examinations of the affairs of insurance companies and require the filing of annual and other reports relating to the financial condition of insurance companies, holding company issues and other matters. Our business depends on compliance with applicable laws and regulations and our ability to maintain valid licenses and approvals for our operations. Regulatory authorities have broad discretion to grant, renew, or revoke licenses and approvals. Regulatory authorities may deny or revoke licenses for various reasons, including the violation of regulations. In some instances, we follow practices based on our interpretations of regulations, or those that we believe to be generally followed by the industry, which may be different from the requirements or interpretations of regulatory authorities. If we do not have the requisite licenses and approvals and do not comply with applicable regulatory requirements, the insurance regulatory authorities could preclude or temporarily suspend us from carrying on some or all of our activities or otherwise penalize us. That type of action could have a material adverse effect on our business. Our failure to comply with new or existing government regulation could subject us to significant fines and penalties. Our efforts to measure, monitor and adjust our business practices to comply with current laws are ongoing. Failure to comply with enacted regulations could result in significant fines, penalties, or the loss of one or more of our licenses. As governmental regulation changes, the costs of compliance may cause us to change our operations significantly, or adversely impact the healthcare provider networks with which we do business, which may adversely affect our business and results of operations. In addition, changes in the level of regulation of the insurance industry (whether federal, state or foreign), or changes in laws or regulations themselves or interpretations by regulatory authorities, could have a material adverse effect on our business.

Item 1B. *Unresolved Staff Comments*

None

Item 2. *Properties*

We currently own and occupy our executive offices located at 9151 Boulevard 26, North Richland Hills, Texas 76180-5605 and 8825 Bud Jensen Drive, North Richland Hills, Texas 76180-5605 comprising in the aggregate approximately 281,000 and 30,000 square feet, respectively, of office and warehouse space. In addition, we lease office space at various locations.

Table of Contents**Item 3. Legal Proceedings**

See Note P of Notes to Consolidated Financial Statements, the terms of which are incorporated by reference herein.

Item 4. Submissions of Matters to a Vote of Security Holders

The Company's Annual Meeting of Stockholders was held on October 12, 2006. As of September 12, 2006 (the record date for the meeting) an aggregate of 29,818,044 shares of Class A-1 and Class A-2 common stock were issued and outstanding. The following individuals were elected to the Company's Board of Directors to hold office for the ensuing year.

Nominee	In Favor	Withheld/Against
Allen F. Wise	26,410,034	0
William J. Gedwed	26,410,034	0
Chinh E. Chu	26,410,034	0
Adrian M. Jones	26,410,034	0
Mural R. Josephson	26,410,034	0
Matthew S. Kabaker	26,410,034	0
Andrew S. Kahr	26,410,034	0
Kamil M. Salame	26,410,034	0
Steven J. Shulman	26,410,034	0
Nathaniel M. Zilkha	26,410,034	0

The results of the voting for the proposal to ratify the change in corporate name from UICI to HealthMarkets, Inc. were as follows:

For	Against	Abstain
26,410,034	0	0

The results of the voting for the proposal to approve of the HealthMarkets 2006 Management Stock Option Plan were as follows:

For	Against	Abstain
26,410,034	0	0

The results of the voting for the proposal to ratify the appointment of KPMG LLP as the Company's independent registered public accounting firm to audit the accounts of the Company for the fiscal year ending December 31, 2006 were as follows:

For	Against	Abstain
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26,410,034

0

0

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Table of Contents**PART II****Item 5. *Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***

The Company's shares were traded on the New York Stock Exchange (NYSE) under the symbol UCI until April 5, 2006, the date of the Merger. The table below sets forth on a per share basis, for the periods indicated, the high and low closing sales prices of the Common Stock on the NYSE.

	High	Low
Fiscal Year Ended December 31, 2005		
1st Quarter	\$ 33.25	\$ 24.10
2nd Quarter	30.56	21.90
3rd Quarter	36.17	29.35
4th Quarter	36.40	35.47
Fiscal Year Ended December 31, 2006		
1st Quarter	\$ 36.99	\$ 35.79
2nd Quarter (through April 5)	37.00	36.97
3rd Quarter	N/A	N/A
4th Quarter	N/A	N/A

Upon completion of the Merger on April 5, 2006 between the Company and affiliates of The Blackstone Group, Goldman Sachs Capital Partners and DLJ Merchant Banking Partners, shares of the Company's Common Stock were delisted from trading on the New York Stock Exchange. Subsequent to such delisting, there has been no established public trading market in our shares.

As of March 9, 2007, there were approximately 31 holders of record of Class A-1 Common Stock and 1,517 holders of record of Class A-2 Common Stock.

On August 18, 2004, the Company's Board of Directors adopted a policy of issuing a regular semi-annual cash dividend on shares of its common stock. In accordance with the dividend policy, on August 18, 2004, the Company's Board of Directors declared a regular semi-annual cash dividend of \$0.25 on each share of Common Stock, which dividend was paid on September 15, 2004 to shareholders of record at the close of business on September 1, 2004. On February 9, 2005, the Company's Board of Directors declared a regular semi-annual cash dividend of \$0.25 per share and a special cash dividend of \$0.25 per share. The regular and special dividend were paid on March 15, 2005 to shareholders of record at the close of business on February 21, 2005. On July 28, 2005, the Company's Board of Directors declared a regular semi-annual cash dividend of \$0.25 on each share of Common Stock, which dividend was paid on September 15, 2005 to shareholders of record at the close of business on August 22, 2005.

Since the execution on September 15, 2005, of a definitive agreement contemplating the acquisition of the Company in a cash merger by a group of private equity firms, the Company has not declared or paid additional dividends on shares of its common stock.

In addition, dividends paid by the Company's domestic insurance subsidiaries to the Company out of earned surplus in any year that are in excess of limits set by the laws of the state of domicile require prior approval of state regulatory authorities in that state.

During the year ended December 31, 2006, the Company issued an aggregate of 74,365 unregistered shares of its Class A-1 common stock to certain newly-appointed executive officers and directors of the Company for an aggregate consideration of \$2.8 million. All such sales of securities were made in reliance upon the exemption from registration provided by Section 4(2) of the Securities Act of 1933, as amended (and/or Regulation D promulgated thereunder) for transactions by an issuer not involving a public offering. The proceeds of such sales were used for general corporate purposes.

Table of Contents**Issuer Purchases of Equity Securities**

Set forth in the table below is certain information with respect to open market purchases by the Company of shares of Common Stock in each month prior to April 5, 2006 (the date of completion of the Merger) (a) pursuant to the authority granted under the Company's previously announced share repurchase program, (b) to facilitate agent-participants' contributions to, and to satisfy the Company's commitment to issue its shares upon vesting of matching credits under, the stock accumulation plans established for the benefit of the Company's agents (*see* Note Q of Notes to Consolidated Financial Statements), and (c) by the trustee for the Company's Employee Stock Ownership and Retirement Savings Plan (which includes shares purchased with employee contributions as well as the portion attributable to the Company's matching contributions prior to the Merger):

Period	Issuer Purchase of Equity Securities - Common Stock			
	Total Number of Shares Purchased(1)	Average Price Paid per Share (\$)	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs(2)	Maximum Number of Shares That May yet be Purchased Under the Plan or Program
01/1/06-01/31/06	13,999	36.17		618,100
02/1/06-02/28/06	33,824	36.65		618,100
03/1/06-03/31/06	44,077	36.86		618,100
04/1/06-04/30/06	2	37.00		
Totals	91,902	36.32		

- (1) The number of shares purchased other than through a publicly announced plan or program includes 15,142 shares purchased with respect to the stock accumulation plans established for the benefit of Company's agents and 76,760 shares purchased for participants in the HealthMarkets 401(k) and Savings Plan. *See* Note R of Notes to Consolidated Financial Statements.
- (2) In November 1998, the Company announced the authorization to repurchase 4,500,000 common shares, and the Company reconfirmed the repurchase program on February 28, 2001 and again on February 11, 2004. On April 28, 2004, the Company announced the authorization to repurchase an additional 1,000,000 common shares under the program. The repurchase program was terminated upon public announcement of the Merger.

Set forth below is a summary of the Company's purchases of shares of HealthMarkets, Inc. Class A-2 common stock following the Merger completed on April 5, 2006, during each of the months in the nine-month period ended December 31, 2006, pursuant to the terms of the Company's agent stock accumulation plans established for the benefit of the Company's agents (*See* Note Q of the Notes to Consolidated Financial Statements):

Issuer Purchase of Equity Securities - Class A-2

Period	Total Number of Shares Purchased(1)	Average Price Paid per Share (\$)	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares That May yet be Purchased Under the Plan or Program
04/1/06-04/30/06	17,662	37.00		
05/1/06-05/31/06	25,092	37.00		
06/1/06-06/30/06	32,011	37.00		
07/1/06-07/31/06	26,611	38.35		
08/1/06-08/31/06	26,684	38.39		
09/1/06-09/30/06	40,251	38.37		
10/1/06-10/31/06	26,125	39.66		
11/1/06-11/30/06	25,988	39.66		
12/1/06-12/31/06	26,169	39.66		
Totals	246,593	38.36		

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- (1) The number of shares purchased other than through a publicly announced plan or program includes 246,593 Class A-2 shares purchased from the stock accumulation plans established for the benefit of the Company's agents. These shares are reflected as treasury shares on the Company's Consolidated Balance Sheet.

Securities Authorized for Issuance under Equity Compensation Plans

The following table sets forth certain information with respect to shares of the Company's Class A-1 and Class A-2 common stock that may be issued under HealthMarkets' equity compensation plans as of December 31, 2006:

Plan Category	Number of Securities to be Issued Upon Exercise of Outstanding Options, Warrants and Rights (a)	Weighted-Average Exercise Price of Outstanding Options, Warrants and Rights (b)	Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)
Equity compensation plans approved by security holders	1,259,115 (1)	\$ 35.51	2,888,208 (2)
Equity compensation plans not approved by security holders(5)	1,491,987 (3)	\$ 0.00	4,496,128 (4)
Total	2,751,102	\$ 16.25	7,384,336

- (1) Includes 97,863 stock options exercisable at a weighted average exercise price of \$9.25 under the UICI 1987 Stock Option Plan. Also includes 1,161,252 stock options granted at a weighted average exercise price of \$37.72 under the HealthMarkets 2006 Management Stock Option Plan.
- (2) Includes securities available for future issuance as follows: UICI 1987 Stock Option Plan, 2,559,719 shares; HealthMarkets 2006 Management Stock Option Plan, 328,489 shares.
- (3) Includes (a) 944,466 shares issuable upon vesting of matching credits granted to participants under the Agency Matching Total Ownership Plan established for the benefit of agents associated with UGA Association Field Services and (b) 547,521 shares issuable upon vesting of matching credits granted to participants under the Matching Agency Contribution Plan established for the benefit of agents associated with Cornerstone America.

- (4) Includes securities available for future issuance as follows: Agents Matching Total Ownership Plan, 2,044,990 shares; Matching Agency Contribution Plan, 2,451,138 shares.
- (5) Effective April 5, 2006, the Agency Matching Total Ownership Plan I and the Agents Matching Total Ownership Plan II (which were established for the benefit of agents associated with UGA Association Field Services) were consolidated, amended and restated and thereafter renamed the HealthMarkets Agency Matching Total Ownership Plan. Also effective April 5, 2006, the Matching Agency Contribution Plan I and the Matching Agency Contribution Plan II (which were established for the benefit of agents associated with Cornerstone America) were consolidated, amended and restated and thereafter renamed the HealthMarkets Matching Agency Contribution Plan. The amended and restated plans were not approved by security holders. *See* Note Q of Notes to Consolidated Financial Statements for additional information regarding the Agency Matching Total Ownership Plan and the Matching Agency Contribution Plan.

Table of Contents**Item 6. Selected Financial Data**

The following selected consolidated financial data as of and for each of the five years in the period ended December 31, 2006 has been derived from the audited Consolidated Financial Statements of the Company. The following data should be read in conjunction with the Consolidated Financial Statements and the notes thereto and *Management's Discussion and Analysis of Financial Condition and Results of Operations* included herein.

	Year Ended December 31,				
	2006	2005	2004	2003	2002
	(In thousands, except per share amounts and operating ratios)				
Income Statement Data:					
Revenues from continuing operations	\$ 2,146,571	\$ 2,121,218	\$ 2,069,109	\$ 1,825,162	\$ 1,380,033
Income from continuing operations before income taxes	352,298	313,150	221,149	131,916	76,759
Income from continuing operations	216,568	202,970	145,881	87,324	51,054
Income (loss) from discontinued operations	21,170	531	15,677	(72,990)	953
Net income	\$ 237,738	\$ 203,501	\$ 161,558	\$ 14,334	\$ 46,863
Per Share Data:					
Earnings per share from continuing operations:					
Basic earnings per common share	\$ 6.19	\$ 4.40	\$ 3.16	\$ 1.88	\$ 1.08
Diluted earnings per common share	\$ 6.07	\$ 4.31	\$ 3.07	\$ 1.82	\$ 1.05
Earnings (loss) per share from discontinued operations:					
Basic earnings (loss) per common share	\$ 0.61	\$ 0.01	\$ 0.34	\$ (1.57)	\$ 0.02
Diluted earnings (loss) per common share	\$ 0.59	\$ 0.01	\$ 0.33	\$ (1.52)	\$ 0.02
Earnings per share:					
Basic earnings per common share	\$ 6.80	\$ 4.41	\$ 3.50	\$ 0.31	\$ 0.99
Diluted earnings per common share	\$ 6.66	\$ 4.32	\$ 3.40	\$ 0.30	\$ 0.96
Operating Ratios:					
Health Ratios:					
Loss ratio(1)	57%	57%	61%	65%	63%
Expense ratio(1)	32%	31%	33%	34%	34%
Combined health ratio	89%	88%	94%	99%	97%

Balance Sheet Data:

Total investments, cash and cash overdraft(2)	\$ 1,834,600	\$ 1,774,188	\$ 1,710,589	\$ 1,579,131	\$ 1,355,918
Total assets	2,588,329	2,371,530	2,345,658	2,126,959	1,915,188
Total policy liabilities	1,135,174	1,174,264	1,258,671	1,184,984	1,028,969
Total debt	556,070	15,470	15,470	18,951	7,922
Student loan credit facilities	118,950	130,900	150,000	150,000	150,000
Stockholders equity	524,385	871,081	714,145	587,568	585,050
Stockholders equity per share(3)	\$ 17.94	\$ 19.05	\$ 15.18	\$ 12.15	\$ 11.76

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- (1) The health loss ratio represents benefits, claims and settlement expenses related to health insurance policies stated as a percentage of earned health premiums. The health expense ratio represents underwriting, policy acquisition costs and insurance expenses related to health insurance policies stated as a percentage of earned health premiums.
- (2) Does not include restricted cash. *See* Note A of Notes to Consolidated Financial Statements.
- (3) Excludes the unrealized gains (losses) on securities available for sale, which gains are reported in accumulated other comprehensive income (loss) as a separate component of stockholders' equity.

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion of our historical results of operations and of our liquidity and capital resources should be read in conjunction with the Selected Financial Data and the Consolidated Financial Statements of the Company and related notes thereto included herein.

Overview

We offer insurance (primarily health and life) to niche consumer and institutional markets. Through our subsidiaries we issue primarily health insurance policies, covering individuals and families, to the self-employed, association groups and small businesses, and life insurance policies to markets that we believe are underserved. We believe that we have the largest direct selling organization in the health insurance field, with approximately 2,100 independent writing agents per week in the field selling health insurance to the self employed market in 44 states.

The Company's revenues have historically consisted primarily of premiums derived from sales of its indemnity, PPO, student group and voluntary employer group health plans and from life insurance policies. Revenues also include investment income derived from our investment portfolio and other income, which consists primarily of income derived by the Self-Employed Agency Division from ancillary services and membership marketing and administrative services provided to the membership associations that make available to their members the Company's health insurance products.

Premiums on health insurance contracts are recognized as earned over the period of coverage on a pro rata basis. Premiums on traditional life insurance are recognized as revenue when due.

The table below sets forth premium by insurance division for each of the three most recent fiscal years (excluding for all periods presented premium associated with our former Star HRG Division and Student Insurance Division, which we disposed of in July and December 2006, respectively):

	Year Ended December 31,		
	2006	2005	2004
	(In thousands)		
Premium:			
Self-Employed Agency Division	\$ 1,330,298	\$ 1,394,644	\$ 1,355,328
Life Insurance Division	65,716	61,936	46,503
Other Insurance	33,873	33,856	14,127

Total premium	\$ 1,429,887	\$ 1,490,436	\$ 1,415,958
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The Company's expenses consist primarily of insurance claims expense and expenses associated with the underwriting and acquisition of insurance policies. Claims expenses consist primarily of payments to physicians, hospitals and other healthcare providers under health policies and include an estimated amount for incurred but not reported and unpaid claims. Underwriting, policy acquisition costs and insurance expenses consist of direct expenses incurred across all insurance lines in connection with issuance, maintenance and administration of in-force insurance policies, including amortization of deferred policy acquisition costs, commissions paid to agents, administrative expenses and premium taxes. The Company also incurs other direct expenses in connection with generating income derived by the Self-Employed Agency Division from ancillary services and membership

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marketing and administrative services provided to the membership associations that make available to their members the Company's health insurance products.

The Company establishes liabilities for benefit claims that have been reported but not paid and claims that have been incurred but not reported under health and life insurance contracts. These claim liabilities are developed using actuarial principles and assumptions that consider a number of items, including historical and current claim payment patterns, product variations, the timely implementation of appropriate rate increases and seasonality. *See* discussion below under the caption "Critical Accounting Policies and Estimates" *Claims Liabilities* and Note G of Notes to Consolidated Financial Statements.

In connection with various stock-based compensation plans that we maintain for the benefit of our employees and independent agents, we record non-cash variable stock-based compensation expense in amounts that depend and fluctuate based upon the fair market value (as determined by the Company's Board of Directors since the Merger) of the Company's common stock. *See* discussion below under the caption "Variable Stock-Based Compensation" and Note Q of Notes to Consolidated Financial Statements. The accounting treatment of the Company's agent plans has resulted and will continue to result in unpredictable stock-based compensation charges, primarily dependent upon future fluctuations in the fair value of HealthMarkets Class A-2 common stock.

The Company's business segments for financial reporting purposes include (i) the Insurance segment (which includes the businesses of the Company's Self-Employed Agency Division (SEA), the Life Insurance Division and Other Insurance); (ii) Other Key Factors (which includes investment income not allocated to the Insurance segment, realized gains or losses on sale of investments, interest expense on corporate debt, general expenses relating to corporate operations, merger transaction expenses, variable non-cash stock-based compensation and operations that do not constitute reportable operating segments); and (iii) Disposed Operations (which includes the Company's former Star HRG Division and former Student Insurance Division).

2006 Sales of Student Insurance Division and Star HRG Division

In July 2006 and December 2006, the Company sold in two separate transactions substantially all of the assets comprising its former Star HRG unit and its former Student Insurance Division. In connection with these sales, in 2006 the Company recorded an aggregate pre-tax gain in the amount of \$201.7 million, of which \$101.5 million was attributable to the Star HRG transaction and \$100.2 million was attributable to the Student Insurance transaction.

As part of the sale transactions, insurance subsidiaries of the Company entered into 100% coinsurance arrangements with each of the purchasers, pursuant to which (a) the purchasers agreed to assume liability for all future claims associated with the Star HRG and Student Insurance blocks of group accident and health insurance policies in force as of the respective closing dates and (b) the Company's insurance subsidiaries transferred to the purchasers cash in an amount equal to the actuarial estimate of those future claims. While under the terms of the coinsurance agreements the Company's insurance subsidiaries have ceded liability for all future claims made on the insurance policies in force at the closing date, the insurance subsidiaries remain primarily liable on those policies. Accordingly, for financial reporting purposes, at December 31, 2006 the Company has reflected and will continue to reflect the policy liabilities ceded to and assumed by the purchasers under the coinsurance agreements as "Policy liabilities" on its Consolidated Balance Sheet, with a corresponding amount recorded as a "Reinsurance receivable" on its Consolidated Balance Sheet. At December 31, 2006, the Company had recorded on its Consolidated Balance Sheet aggregate policy liabilities in the amount of \$1.1 billion, of which \$134.1 million was attributable to the Star HRG and Student Insurance policy liabilities ceded to and assumed by the purchasers under the coinsurance agreements. Correspondingly, at December 31, 2006, the Company had recorded a reinsurance receivable in the amount of \$155.3 million, of which an aggregate of \$132.8 million was attributable to the Star HRG and Student Insurance coinsurance agreements. In addition, for financial reporting purposes the Company will continue to report in future periods the residual results of

operations of these businesses (anticipated to consist solely of residual wind-down expenses and any true-up, claw-back or earn-out items associated with the sales) in continuing operations and classified to the Company's Disposed Operations business segment.

See Note C of Notes to Consolidated Financial Statements for additional information regarding the terms of the sales of the Star HRG Division and Student Insurance Division assets.

Table of Contents**Results of Operations Overview**

During 2006, the Company's financial condition, cash flow and results from operations were impacted by the following key factors and developments:

Sale of Star HRG Division and Student Insurance Division

The Company's 2006 results of operations reflected significant one-time gains recognized in connection with the sales of the Company's Star HRG unit and Student Insurance Division, which were sold by the Company in July and December of 2006, respectively. In particular, the Company recorded an aggregate pre-tax gain associated with these sales in the amount of \$201.7 million, of which \$101.5 million was attributable to the Star HRG transaction and \$100.2 million was attributable to the Student Insurance transaction.

Results at SEA Division

The Company's 2006 results from continuing operations reflected a 24% year-over-year decrease in operating income at its SEA Division. The SEA Division reported operating income in 2006 of \$236.5 million, compared to operating income of \$310.5 million in 2005. Results at the Company's SEA Division in 2006 were negatively impacted by an increase in the health loss ratio (which increased to 54.3% in 2006 from 51.5% in 2005) and additional expense in the amount of \$15.5 million associated with a change in accounting policy with respect to amortization of a portion of deferred acquisition costs. See the discussion below under the caption 2006 Change in Accounting Methodology.

Significant Merger Costs

During the second quarter of 2006, the Company utilized cash in the amount of approximately \$120.9 million for professional fees and expenses associated with the Merger. Of this total cash expended, \$47.3 million (\$38.2 million, net of tax) was expensed and charged to income in the second quarter of 2006 (which expenses are reflected under the caption Other expenses on the Company's Consolidated Statement of Operations), \$31.7 million of fees and expenses related to raising equity in the Merger was reflected as a direct reduction in stockholders' equity, and \$41.9 million (\$9.4 million of prepaid monitoring fees and \$32.5 million of capitalized financing costs attributable to the issuance of the debt in the Merger) was capitalized (which capitalized financing costs are reflected under the caption Other assets on the Company's Consolidated Balance Sheet). As of December 31, 2006 all of the prepaid monitoring fees and \$6.3 million of the capitalized financing cost had been amortized. See Note I. The Company did not incur any additional Merger transaction costs through the remainder of 2006.

Interest Expense on Debt Incurred in the Merger

During 2006, the Company incurred interest expense in the amount of \$28.6 million associated with indebtedness incurred in connection with the Merger completed on April 5, 2006. In connection with the Merger, the Company borrowed \$500.0 million under a term loan credit facility and issued \$100.0 million of Floating Rate Junior Subordinated Notes. See Note I of Notes to Consolidated Financial Statements

Improved Results at Disposed Operations

The Company's 2006 results from continuing operations benefited from improved results at its former Student Insurance Division, which the Company sold in December 2006. The Company's Student Insurance Division reported operating earnings of \$12.2 million in 2006 (through its date of sale on December 1, 2006), compared to operating losses of \$(8.9) million in 2005. This improved performance reflected more favorable loss experience on the Student

Insurance book of business, lower administrative expenses as a percentage of earned premium and better utilization of network service agreements with healthcare providers.

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2006 Change in Accounting Policy

Effective December 31, 2006, the Company changed its accounting policy with respect to the amortization of a portion of deferred acquisition costs associated with commissions paid to agents.

The Company formerly capitalized commissions and premium taxes associated with its SEA Division business (classified as deferred acquisition costs (DAC)) and amortized all of these costs over the period (and in proportion to the amount) that the associated unearned premium was earned. The Company utilized this accounting methodology in preparing its reported 2006 interim financial statements.

Following adoption of SEC Staff Accounting Bulletin No. 108 (SAB 108), *Considering the Effects of Prior Year Misstatements when Quantifying Misstatements in the Current Year Financial Statements*, the Company recently performed an analysis to determine the appropriate portion of commissions to be deferred over the lives of the underlying policies. Generally, first year and second year commission rates are higher than the renewal year commission rates, and the Company has determined that the preferred approach is to capitalize the excess commissions associated with those earlier years and amortize the capitalized costs ratably over the estimated life of the policy, rather than in the year the commissions were paid. Accordingly, effective January 1, 2006 the Company has elected to change its accounting methodology by amortizing the first and second year excess commissions ratably over a two year period (based on recent persistency studies showing that SEA policies have an average life of 2.09 years).

The Company has elected to utilize the one time special transition provisions of SAB 108 and recorded an adjustment to retained earnings effective January 1, 2006 to reflect this change in accounting policy with respect to the capitalization and amortization of deferred acquisition costs associated with excess first and second year commissions. As of January 1, 2006, the change in accounting policy resulted in an increase in the Company's capitalized deferred acquisition cost (DAC) of \$77.6 million, a related increase to its deferred tax liability by \$27.1 million, and a net increase to shareholders' equity of \$50.5 million. The adoption of this new accounting policy had the effect of increasing reported underwriting, policy acquisition costs and insurance expenses (classified to its SEA Division) in 2006 by the amount of \$15.5 million and, correspondingly, reducing after-tax net income by \$10.1 million. The Company has reflected the effects of this change in accounting policy for the 2006 interim periods in the Quarterly Results table in *Management's Discussion and Analysis of Financial Condition and Results of Operations*.

Over time, the Company's prior accounting policy with respect to amortization of the excess first and second year commissions resulted in an understatement of an asset (by 4% in 2004 and by 3% in 2005) and shareholders' equity (by 8% in 2004 and by 6% in 2005). In addition, had the Company in prior periods properly deferred and amortized excess first and second year commissions over the average policy life of two years, the Company's previously reported 2005 net income would have been reduced by \$8.5 million (or by less than 4%) and the Company's previously reported 2004 net income would have been reduced by \$698,000 (or by less than 1%). Prior to the adoption of SAB 108, the Company considered the guidance contained in SEC Staff Accounting Bulletin No. 99, *Materiality*, using the *roll-over* method (which has as its primary focus the income statement, including the reversing effect of prior year misstatements) and concluded that its previously reported results of operations for the SEA Division for the years ending 2003 through 2005 were not materially distorted.

Table of Contents**Results of Operations**

The table below sets forth certain summary information about our consolidated operating results for each of the three most recent fiscal years:

	Year Ended December 31,				
	2006	Percentage Increase (Decrease)	2005	Percentage Increase (Decrease)	2004
(Dollars in thousands)					
Revenue					
Premiums:					
Health	\$ 1,671,571	(10)%	\$ 1,855,969	2%	\$ 1,812,892
Life premiums and other considerations	65,675	7%	61,565	34%	45,851
Total premium	1,737,246	(9)%	1,917,534	3%	1,858,743
Investment income	104,147	7%	97,788	14%	85,868
Other income	104,634	(2)%	106,656	(9)%	117,827
Gains (losses) on sale of investments	200,544	NM	(760)	NM	6,671
Total revenues	2,146,571	1%	2,121,218	3%	2,069,109
Benefits and Expenses					
Benefits, claims, and settlement expenses	996,617	(9)%	1,092,136	(4)%	1,134,901
Underwriting, policy acquisition costs, and insurance expenses	581,163	(6)%	621,532	(1)%	625,761
Variable stock compensation expense	16,603	130%	7,214	(50)%	14,307
Other expenses	158,749	96%	81,177	17%	69,574
Interest expense	41,141	NM	6,009	76%	3,417
Total benefits and expenses	1,794,273	(1)%	1,808,068	(2)%	1,847,960
Income from continuing operations before income taxes	352,298	13%	313,150	42%	221,149
Federal income taxes	135,730	23%	110,180	46%	75,268
Income from continuing operations	216,568	7%	202,970	39%	145,881
Income from discontinued operations (net of income tax benefit)	21,170	NM	531	NM	15,677
Net income	\$ 237,738	17%	\$ 203,501	NM	\$ 161,558

NM: not meaningful

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The table below sets forth certain summary information about our consolidated operating results for each of the three most recent fiscal years. For purposes of this presentation, we have reclassified and netted the operating revenues and expenses attributable to our former Star HRG Division and Student Insurance Division (which we disposed of in July and December 2006, respectively) to the line item Income (loss) from Student Insurance operations and Star HRG operations (net of income tax) :

	Year Ended December 31,				
	2006	Percentage Increase (Decrease)	2005	Percentage Increase (Decrease)	2004
	(Dollars in thousands)				
Revenue					
Premiums:					
Health	\$ 1,364,212	(5)%	\$ 1,428,871	4%	\$ 1,370,107
Life premiums and other considerations	65,675	7%	61,565	34%	45,851
Total premium	1,429,887	(4)%	1,490,436	5%	1,415,958
Investment income	98,896	9%	90,964	15%	78,962
Other income	101,817	(2)%	103,562	(6)%	110,730
Gains (losses) on sale of investments	200,544	NM	(760)	NM	6,671
Total revenues	1,831,144	9%	1,684,202	4%	1,612,321
Benefits and Expenses					
Benefits, claims, and settlement expenses	784,896	1%	777,695	NM	776,449
Underwriting, policy acquisition costs, and insurance expenses	492,003	NM	491,521	2%	481,263
Variable stock compensation expense	16,603	130%	7,214	(50)%	14,307
Other expenses	158,749	96%	81,177	17%	69,574
Interest expense	41,141	NM	6,009	76%	3,417
Total benefits and expenses	1,493,392	10%	1,363,616	1%	1,345,010
Income from continuing operations before income taxes	337,752	5%	320,586	20%	267,311
Federal income taxes	130,639	16%	112,782	23%	91,425
Income from continuing operations (excluding Student Insurance operations and Star HRG operations)	207,113	1%	207,804	18%	175,886
Income from discontinued operations (net of income tax benefit)	21,170	NM	531	(97)%	15,677
Income excluding Student Insurance operations and Star HRG operations	228,283	10%	208,335	9%	191,563
	9,455	NM	(4,834)	(84)%	(30,005)

Income (loss) from Student Insurance operations (net of tax benefit (expense) of \$(4,283), \$3,105 and \$17,319 for 2006, 2005 and 2004, respectively) and Star HRG operations (net of tax benefit (expense) of \$(808), \$(502) and \$(1,162) for 2006, 2005 and 2004, respectively)(a)

Net income	\$	237,738	17%	\$	203,501	26%	\$	161,558
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(a) See Management's Discussion and Analysis of Financial Condition and Results of Operations 2006 Compared to 2005, Disposed Operations.

NM: not meaningful

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Revenues and income from continuing operations before federal income taxes (operating income) for each of the Company's business segments and divisions in 2006, 2005 and 2004 was as follows:

	Year Ended December 31,		
	2006	2005	2004
	(In thousands)		
<i>Revenues:</i>			
<i>Insurance:</i>			
Self-Employed Agency Division	\$ 1,462,088	\$ 1,525,968	\$ 1,496,199
Life Insurance Division	87,782	83,037	67,613
Other Insurance(1)	35,337	34,799	14,388
Total Insurance	1,585,207	1,643,804	1,578,200
Other Key Factors	246,847	41,104	34,719
Inter-segment Eliminations	(910)	(706)	(598)
Total revenues excluding Disposed Operations	1,831,144	1,684,202	1,612,321
<i>Disposed Operations:</i>			
Student Insurance Division	240,050	290,378	306,325
Star HRG Division	75,377	146,638	150,463
Total Disposed Operations	315,427	437,016	456,788
Total revenues	\$ 2,146,571	\$ 2,121,218	\$ 2,069,109
<i>Income from continuing operations before federal income tax:</i>			
<i>Insurance:</i>			
Self-Employed Agency Division	\$ 236,466	\$ 310,466	\$ 260,745
Life Insurance Division	5,264	7,053	4,690
Other Insurance(1)	5,488	4,658	1,415
Total Insurance	247,218	322,177	266,850
<i>Other Key Factors:</i>			
Investment income on equity, realized gains and losses, general corporate expenses and other (including interest on corporate debt)	155,156	14,680	14,768
Merger transaction costs(2)	(48,019)	(9,057)	
Variable stock-based compensation	(16,603)	(7,214)	(14,307)
Total Other Key Factors	90,534	(1,591)	461
<i>Disposed Operations:</i>			
Student Insurance Division	12,238	(8,870)	(49,482)
Star HRG Division	2,308	1,434	3,320

Total Disposed Operations	14,546	(7,436)	(46,162)
Total income from continuing operations before federal income taxes	\$ 352,298	\$ 313,150	\$ 221,149

- (1) Reflects results of a subsidiary (ZON Re USA LLC) established in the third quarter of 2003 to underwrite, administer and issue accidental death, accidental death and dismemberment (AD&D), accident medical and accident disability insurance products, both on a primary and on a reinsurance basis.
- (2) Includes the incremental costs associated with the acquisition of the Company by a group of private equity investors.

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2006 Compared to 2005

In 2006 HealthMarkets reported consolidated revenues and income from continuing operations of \$2.147 billion and \$216.6 million (\$6.07 per diluted share), respectively, compared to revenues and income from continuing operations in 2005 of \$2.121 billion and \$203.0 million (\$4.31 per diluted share), respectively. Reflecting results from discontinued operations, the Company reported overall 2006 net income of \$237.7 million (\$6.66 per diluted share), compared to 2005 net income of \$203.5 million (\$4.32 per diluted share).

Unless the context indicates otherwise, the following discussion comparative of our 2006 and 2005 results of operations excludes the operations of the Company's Student Insurance Division and Star HRG Division which were sold in July and December 2006, respectively.

Continuing Operations

Revenues. HealthMarkets' revenues increased to \$1.831 billion in 2006 from \$1.684 billion in 2005, an increase of \$146.9 million, or 9%. The Company's revenues were particularly impacted by the following factors:

The Company experienced a 5% decrease in health premium revenue (to \$1.364 billion in 2006 from \$1.429 billion in 2005). This decrease was attributable to the decline in submitted annualized premium volume at the SEA Division in years prior to 2006. However, during 2006, annualized premium volume increased by 10% over annualized premium volume in 2005.

Life premiums and other considerations increased by 7%, to \$65.7 million in 2006 from \$61.6 million in 2005. This increase was attributable primarily to incremental sales of life products through relationships with two independent marketing companies and growth in renewal business from life products sold during 2004 and 2005.

Due to an increase in the prevailing yield on short-term securities, student loans and other investments, investment income increased to \$98.9 million in 2006 compared to \$91.0 million in 2005.

Other income (consisting primarily of income derived by the SEA Division from ancillary services and membership marketing and administrative services provided to the membership associations that make available to their members the Company's health insurance products) decreased by 2% to \$101.8 million in 2006 from \$103.6 million in 2005. The decrease in other income was primarily attributable to a decrease in fee and other income earned by the Company's former real estate subsidiary, the activities of which were immaterial and which the Company is dissolving in the first quarter of 2007.

In 2006, the Company recognized net gains on sale of investments of \$200.5 million compared to losses on sales of investments of \$(760,000) in 2005. The increase in 2006 was primarily attributable to gains realized from the sales of the Company's Star HRG Division and the Student Insurance Division in 2006.

Benefits and Expenses. HealthMarkets' total benefits and expenses increased to \$1.493 billion in 2006 from \$1.364 billion in 2005, an increase of \$129.8 million, or 10%. The Company's benefits and expenses were particularly impacted by the following factors:

Despite a 5% decrease in health premium revenue, benefits, claims and settlement expenses increased nominally to \$784.9 million in 2006 from \$777.7 million in 2005, primarily as a result of an increase in the claim benefits as a percentage of earned premium associated with business written at the SEA Division. *See*

Self-Employed Agency discussion below.

Underwriting costs, policy acquisition costs and insurance expenses remained virtually unchanged in the periods (\$492.0 million in 2006 and \$491.5 million in 2005). A decrease in administrative expenses in 2006 at the SEA Division was somewhat offset by additional amortization of capitalized acquisition costs in the amount of \$15.5 million associated with a change in the Company's method of accounting for a portion of deferred acquisition costs. *See* discussion above under the caption "2006 Change in Accounting Policy."

The Company maintains for the benefit of its independent agents various stock-based compensation plans, in connection with which it records non-cash variable stock-based compensation expense (benefit) in amounts that depend and fluctuate based upon the performance of the Company's common stock. In 2006, the

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Company recognized a non-cash stock based compensation expense in the amount of \$16.6 million, compared to non-cash stock based compensation expense of \$7.2 million in 2005. The increase is principally due to greater change in share price during 2006 compared to 2005.

Other expenses (consisting primarily of direct expenses incurred by the Company in connection with providing ancillary services and membership marketing and administrative services provided to the membership associations that make available to their members the Company's health insurance products and general expenses relating to corporate operations) increased to \$158.7 million in 2006 from \$81.2 million in 2005. The majority of the increase is attributed to incremental costs in the amount of \$48.0 million associated with the Merger, \$9.4 million of advisory fees incurred since the Merger date for services provided by the Private Equity Investors and additional overhead expenses incurred in connection with the previously announced corporate name change and branding initiative.

Total interest expense on corporate debt and the Company's student loan credit facilities increased to \$41.1 million in 2006 from \$6.0 million in 2005, primarily due to the incremental indebtedness incurred in connection with the Merger and the increase in borrowing rates on the student loan debt.

Operating Income. Operating income (exclusive of operating results at the Company's Star HRG Division and Student Insurance Division) increased by 5% to \$337.8 million in 2006 from \$320.6 million in 2005. As discussed more fully below, the Company's 2006 results from continuing operations benefited from realized gains of \$201.7 million recorded upon the sales of the Star HRG and Student Insurance divisions. These gains were offset by an increase in Merger costs of \$39.0 million (from \$9.0 million in 2005 to \$48.0 million in 2006), a \$35.1 million increase in interest expense (from \$6.0 million in 2005 to \$41.1 million in 2006) and a 24% decrease in operating income at the SEA Division (from \$310.5 million in 2005 to \$236.5 million in 2006).

Our operating segments for financial reporting purposes include (a) the Insurance segment, which includes the businesses of the Company's Self-Employed Agency (SEA) Division, the Life Insurance Division and Other Insurance, (b) Other Key Factors, which includes investment income not otherwise allocated to the Insurance segment, realized gains and losses, interest expense on corporate debt, general expenses relating to corporate operations, variable stock compensation and other unallocated items, and (c) Disposed Operations, which includes the Company's former Star HRG Division and former Student Insurance Division (which operations were sold on July 11, 2006 and December 1, 2006, respectively).

Table of Contents*Self-Employed Agency Division*

Set forth below is certain summary financial and operating data for the Company's Self-Employed Agency (SEA) Division for each of the three most recent fiscal years:

	Year Ended December 31,				
	2006	Percentage Increase (Decrease)	2005	Percentage Increase (Decrease)	2004
(Dollars in thousands)					
<i>Revenues:</i>					
Earned premium revenue	\$ 1,330,298	(5)%	\$ 1,394,644	3%	\$ 1,355,328
Investment income(1)	31,809	(3)%	32,725	(3)%	33,640
Other income	99,981	1%	98,599	(8)%	107,231
Total revenues	1,462,088	(4)%	1,525,968	2%	1,496,199
<i>Expenses:</i>					
Benefits expenses	721,688	0%	718,502	(2)%	736,678
Underwriting and acquisition expenses	444,032	0%	445,411	0%	445,737
Other expenses(1)	59,902	16%	51,589	(3)%	53,039
Total expenses	1,225,622	1%	1,215,502	(2)%	1,235,454
Operating income	\$ 236,466	(24)%	\$ 310,466	19%	\$ 260,745
<i>Other operating data:</i>					
Loss ratio(2)	54.3%	5%	51.5%	(5)%	54.4%
Expense ratio(2)	33.3%	4%	32.0%	(3)%	32.9%
Combined health ratio	87.6%	5%	83.5%	(4)%	87.3%
Operating margin(3)	17.8%	(20)%	22.3%	16%	19.2%
Average number of writing agents in period	2,143	5%	2,039	(12)%	2,329
Submitted annualized volume(4)	\$ 791,152	10%	\$ 720,448	(16)%	\$ 860,377

(1) Allocations of investment income and certain general expenses are based on a number of assumptions and estimates, and the business division's reported operating results would change if different methods were applied.

(2) The health loss ratio represents benefits, claims and settlement expenses related to health insurance policies stated as a percentage of earned health premiums. The health expense ratio represents underwriting, policy acquisition costs and insurance expenses related to health insurance policies stated as a percentage of earned health premiums.

- (3) Operating margin is defined as operating income as a percentage of earned premium revenue.
- (4) Submitted annualized premium volume in any period is the aggregate annualized premium amount associated with health insurance applications submitted by the Company's agents in such period for underwriting by the Company.

For 2006, the SEA Division reported operating income of \$236.5 million compared to operating income of \$310.5 million in 2005. Operating income at the SEA Division as a percentage of earned premium revenue (*i.e.*, operating margin) in 2006 was 17.8% compared to 22.3% in 2005.

Operating income at the SEA Division in 2006 was negatively impacted by a decrease in earned premium revenue, an increase in the loss ratio (benefits as a percentage of earned premium), and an increase in underwriting, policy acquisition costs and insurance expenses as a percentage of earned premium. Earned premium revenue at the SEA Division decreased to \$1.330 billion in 2006 compared to earned premium revenue of \$1.395 billion in 2005. The decrease in earned premium revenue at the Self-Employed Agency division during 2006 was due to the decline in submitted annualized premium volume in 2004 and 2005. However, during 2006, annualized premium volume increased by 10% over annualized premium volume in 2005. The increase in the loss ratio was due to a product mix shift to new health insurance products in the Company's recently-introduced CareOne product suite and cost

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containment expenses resulting from the Company's initiatives to control medical costs. Products in the CareOne product suite (sales of which in 2006 represented approximately 14% of total SEA Division earned premium revenue) are expected to provide a higher proportion of the premium as benefits. In 2006, underwriting, policy acquisition costs and insurance expenses included additional amortization of capitalized policy acquisition costs in the amount of \$15.5 million associated with a change in the Company's method of accounting for a portion of deferred acquisition costs. *See* Management's Discussion and Analysis of Financial Condition and Results of Operations "2006 Change in Accounting Policy" above.

At December 31, 2006, the Company changed its accounting policy, effective January 1, 2006, with respect to the amortization of a portion of deferred acquisition costs associated with commissions paid to agents. Generally, first year and second year commission rates are higher than the renewal year commission rates, and the Company amortized (*i.e.*, charged to income) the excess commissions associated with those earlier years ratably over the estimated life of the policy rather than in the year the commission is paid. Accordingly, the Company has elected to amortize the first and second year excess commissions over a two year period, based on recent persistency studies indicating that SEA policies have an average life of 2.09 years. Applying recently adopted SEC Staff Accounting Bulletin No. 108 as of January 1, 2006, the Company has determined that adoption of this new accounting policy with respect to the amortization of the excess first and second year commissions had the effect of increasing reported underwriting, policy acquisition costs and insurance expenses in 2006 by the amount of \$15.5 million. *See* Note A of Notes to Consolidated Financial Statements.

Results for the year ended December 31, 2006, also reflected a benefit in the amount of \$47.1 million attributable to refinements of the Company's estimate for its claim liability on its health insurance products. Of the \$47.1 million of refinements to the estimated claim liability, \$44.5 million is attributable to prior years.

Approximately \$11.2 million of the benefit (recorded in the third quarter) was due to refinements of the estimate of the unpaid claim liability for the most recent incurral months. The calculation of the claim liability now distinguishes between more mature products with reliable historical data and newer or lower volume products that have not established a reliable historical trend. Had this refinement been made at December 31, 2005, the claim liability estimate would have been reduced by \$14.8 million.

An additional adjustment to the claim liability (approximately \$25.1 million, of which \$10.5 million was recorded in the third quarter and \$14.6 million was recorded in the fourth quarter) was attributable to an update of the completion factors used in estimating the claim liability for the Accumulated Covered Expense (ACE) rider, an optional benefit rider available with certain scheduled/basic health insurance products that provides for catastrophic coverage for covered expenses under the contract that generally exceed \$100,000 or, in certain cases, \$75,000. This rider pays benefits at 100% after the stop loss amount is reached, up to the aggregate maximum amount of the contract for expenses covered by the rider. This adjustment to the claim liability reflects both actual historical data for the ACE rider and historical data derived from other products. Previously, the completion factors were calculated with more emphasis placed on historical data derived from other products, since there was insufficient data related to the ACE product rider to provide accurate and reliable completion factors. Had these refinements been made at December 31, 2005, the claim liability estimate would have been reduced by \$19.1 million.

In the second quarter of 2006, the Company determined that sufficient provision for large claims could be made within its normal reserve process, eliminating the need for a previously-established separate large claim reserve. This refinement resulted in a reduction in the claim liability of \$10.8 million. Had this refinement been made at December 31, 2005, the claim liability estimate would have been reduced by \$10.6 million.

During 2005, the Company recorded a benefit in the amount of \$40.9 million attributable to various refinements to the Company's estimate of its claim liability.

The decrease in operating margin to 17.8% in 2006 compared to 22.3% in 2005 was attributable primarily to the increase in loss ratio and increase in underwriting, policy acquisition costs and insurance expenses in the amount of \$15.5 million associated with a change in accounting policy with respect to amortization of a portion of deferred acquisition costs. *See* Note A of Notes to Consolidated Financial Statements.

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Total submitted annualized premium volume at the SEA Division increased by 10%, to \$791.2 million in 2006 from \$720.4 million in 2005. The increase in submitted annualized premium volume can be attributed primarily to an increase in the average number of writing agents per week in the field (from 2,039 in 2005 to 2,143 in 2006) and an increase in writing agent productivity. During 2006, the amount of weekly submitted annualized premium volume per writing agent increased by 4.5%, even as the average premium per policy decreased by 4.5%.

Life Insurance Division

Set forth below is certain summary financial and operating data for the Company's Life Insurance Division for each of the three most recent fiscal years:

	Year Ended December 31,		Year Ended December 31,		2004
	2006	Percentage Increase (Decrease)	2005	Percentage Increase (Decrease)	
	(Dollars in thousands)				
Revenues:					
Earned premium revenue	\$ 65,716	6%	\$ 61,936	33%	\$ 46,503
Investment income(1)	20,222	(1)%	20,349	0%	20,425
Other income	1,844	145%	752	10%	685
Total revenues	87,782	6%	83,037	23%	67,613
Expenses:					
Benefits expenses	44,459	12%	39,684	18%	33,613
Underwriting and acquisition expenses(1)	38,059	5%	36,300	24%	29,310
Total expenses	82,518	9%	75,984	21%	62,923
Operating income	\$ 5,264	(25)%	\$ 7,053	50%	\$ 4,690

(1) Allocations of investment income and certain general expenses are based on a number of assumptions and estimates, and the business division's reported operating results would change if different methods were applied.

The Company's Life Insurance Division reported operating income in 2006 of \$5.3 million compared to operating income of \$7.1 million in 2005. The year-over-year decrease in operating income was attributable to an increase in death claims during the first half of 2006 and an increase in administrative expenses, due to a decrease in capitalized deferred acquisition costs (administration costs) related to a decline in first year sales volume.

In 2006, the Company's Life Insurance Division generated annualized paid premium volume (*i.e.*, the aggregate annualized life premium amount associated with new life insurance policies issued by the Company) in the amount of \$20.0 million compared to \$32.9 million in 2005. Annualized paid premium volume for 2006 was negatively impacted by service issues associated with an outside vendor that assists the Company in gathering key underwriting information, and a delay in production due to the introduction of redesigned products that are expected to improve return on capital.

Table of Contents*Other Insurance*

Set forth below is certain summary financial and operating data for the Company's Other Insurance division for each of the three most recent fiscal years:

	Year Ended December 31,				
	2006	Percentage Increase (Decrease)	2005	Percentage Increase (Decrease)	2004
(Dollars in thousands)					
<i>Revenues:</i>					
Earned premium revenue	\$ 33,873	0%	\$ 33,856	140%	\$ 14,127
Investment income(1)	1,356	73%	783	593%	113
Other income	108	(33)%	160	8%	148
Total revenues	35,337	2%	34,799	142%	14,388
<i>Expenses:</i>					
Benefits expenses	18,748	(4)%	19,508	217%	6,158
Underwriting and acquisition expenses(1)	11,101	4%	10,633	56%	6,815
Total expenses	29,849	(1)%	30,141	132%	12,973
Operating income	\$ 5,488	18%	\$ 4,658	229%	\$ 1,415
<i>Other operating data:</i>					
Loss ratio(2)	55.3%	(4)%	57.6%	32%	43.6%
Expense ratio(2)	32.8%	4%	31.4%	(35)%	48.2%
Combined health ratio	88.1%	(1)%	89.0%	(3)%	91.8%
Operating margin(3)	16.2%	17%	13.8%	38%	10.0%

(1) Allocations of investment income and certain general expenses are based on a number of assumptions and estimates, and the business division's reported operating results would change if different methods were applied.

(2) The loss ratio represents benefits, claims and settlement expenses related to accident insurance and reinsurance contracts stated as a percentage of earned premiums. The expense ratio represents underwriting, contract acquisition costs and expenses related to accident insurance and reinsurance contracts stated as a percentage of earned premiums.

(3) Operating margin is defined as operating income as a percentage of earned premium revenue.

The Other Insurance division consists of the operations of ZON Re USA LLC (an 82.5%-owned subsidiary), which underwrites, administers and issues accidental death, accidental death and dismemberment (AD&D), accident medical and accident disability insurance products, both on a primary and on a reinsurance basis. In 2006, ZON Re generated

revenues and operating income of \$35.3 million and \$5.5 million, respectively, compared to revenues and operating income of \$34.8 million and \$4.7 million, respectively, in 2005.

Other Key Factors

The Company's Other Key Factors segment includes investment income not otherwise allocated to the Insurance segment, realized gains and losses, interest expense on corporate debt, variable stock compensation and other unallocated items and general expenses relating to corporate operations. In 2005 and 2006, the incremental costs associated with the acquisition of the Company by a group of private equity investors were also reflected in the results of the Other Key Factors segment.

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Set forth below is a summary of the components of operating income at the Company's Other Key Factors segment for each of the three most recent fiscal years:

	Year Ended December 31,				
	2006	Percentage Increase (Decrease)	2005	Percentage Increase (Decrease)	2004
(Dollars in thousands)					
<i>Operating income:</i>					
Investment income on equity	\$ 35,563	10%	\$ 32,418	83%	\$ 17,735
Realized gain on sale of Star HRG	101,497	NM		NM	
Realized gain on sale of Student Insurance	100,166	NM		NM	
Realized gains (losses) on investments	1,458	NM	(760)	110%	7,606
Expense related to early extinguishment of debt	(2,637)	NM		NM	
Merger transaction expenses	(48,019)	430%	(9,057)	NM	
Interest expense on non-student loan debt	(34,823)	NM	(1,148)	6%	(1,083)
Interest expense on student loan debt	(6,318)	30%	(4,861)	108%	(2,334)
Variable stock-based compensation expense	(16,603)	130%	(7,214)	(50)%	(14,307)
General corporate expenses and other	(39,750)	262%	(10,969)	53%	(7,156)
Operating income (loss)	\$ 90,534	NM	\$ (1,591)	(301)%	\$ 461

NM: Not meaningful

The Other Key Factors segment reported operating income in 2006 of \$90.5 million, compared to an operating loss of \$(1.6) million in 2005.

The increase in operating income in the Other Key Factors segment in 2006 reflected the gains of approximately \$201.7 million on the sales of substantially all of the assets comprising the Company's Star HRG and Student Insurance operations completed in 2006. Results in 2006 also included Merger transaction costs in the amount of \$48.0 million. The increase in interest expense on non-student loan debt in the 2006 period was due to the Merger-related indebtedness incurred in the second quarter of 2006. In connection with the Merger, the Company borrowed \$500.0 million under a term loan credit facility and issued \$100.0 million of Floating Rate Junior Subordinated Notes. See Note I of Consolidated Financial Statements.

Other significant items affecting the 2006 results in the Other Key Factors segment included a \$9.4 million increase in variable stock-based compensation and an increase in general corporate expenses for the period to \$39.8 million compared to \$11.0 million incurred in the comparable period in 2005. These additional overhead expenses were principally associated with the change of the Company's corporate name, the Company's corporate branding initiative and monitoring fees paid to the Private Equity Investors. See Note O of Notes to Consolidated Financial Statements.

Disposed Operations

On July 11, 2006 and December 1, 2006, the Company completed the sales of the assets formerly comprising its Star HRG and Student Insurance Divisions, respectively. *See* Note C of Notes to Consolidated Financial Statements.

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Set forth below is certain summary financial and operating data for the Company's former Student Insurance Division for each of the three most recent fiscal years:

	Year Ended December 31,				
	2006(4)	Percentage Increase (Decrease)	2005	Percentage Increase (Decrease)	2004
(Dollars in thousands)					
Revenues:					
Earned premium revenue	\$ 233,280	(17)%	\$ 282,486	(5)%	\$ 297,036
Investment income(1)	4,882	(20)%	6,121	1%	6,089
Other income	1,888	7%	1,771	(45)%	3,200
Total revenues	240,050	(17)%	290,378	(5)%	306,325
Expenses:					
Benefits expenses	165,334	(26)%	222,306	(16)%	265,698
Underwriting and acquisition expenses(1)	62,478	(19)%	76,942	(15)%	90,109
Total expenses	227,812	(24)%	299,248	(16)%	355,807
Operating income (loss)	\$ 12,238	(238)%	\$ (8,870)	NM	\$ (49,482)
<i>Other operating data:</i>					
Loss ratio(2)	70.9%	(10)%	78.7%	(12)%	89.4%
Expense ratio(2)	26.8%	(1)%	27.2%	(11)%	30.4%
Combined health ratio	97.7%	(8)%	105.9%	(12)%	119.8%
Operating margin(3)	5.2%	NM	(3.1)%	NM	(16.7)%

(1) Allocations of investment income and certain general expenses are based on a number of assumptions and estimates, and the business division's reported operating results would change if different methods were applied.

(2) The health loss ratio represents benefits, claims and settlement expenses related to health insurance policies stated as a percentage of earned health premiums. The health expense ratio represents underwriting, policy acquisition costs and insurance expenses related to health insurance policies stated as a percentage of earned health premiums.

(3) Operating margin is defined as operating income as a percentage of earned premium revenue.

(4) The Student Insurance Division was sold on December 1, 2006. Except for some minor transition expenses recorded in December 2006, the 2006 amounts represent eleven months of activity.

NM: Not meaningful

The Company's Student Insurance Division (which offered tailored health insurance programs that generally provide single school year coverage to individual students at colleges and universities) reported operating income of \$12.2 million in 2006 compared to operating losses of \$(8.9) million in 2005. Results for 2006 at the Student Insurance Division reflected a significant improvement in loss experience on the Student Insurance book of business. The loss ratio on this business decreased to 70.9% in 2006, from 78.7% in 2005, which reflected the benefits of non-renewing certain underperforming schools for the 2005-2006 school year. For 2006, operating results also benefited from lower administrative expenses as a percentage of earned premium and from better utilization of network service agreements with healthcare providers. Earned premium revenue at the Student Insurance Division decreased to \$233.3 million in 2006, from \$282.5 million in 2005. The decrease in premium reflected, in part, the non-renewal in the 2005-2006 school year of certain accounts that had performed poorly in the 2004-2005 school year. In addition, premium in 2006 reflected eleven months of activity through the date of sale.

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Set forth below is certain summary financial and operating data for the Company's former Star HRG Division (which designed, marketed and administered limited benefit health insurance plans for entry level, high turnover, and hourly employees) for each of the three most recent fiscal years:

	Year Ended December 31,				
	2006(4)	Percentage Increase (Decrease)	2005	Percentage Increase (Decrease)	2004
	(Dollars in thousands)				
Revenues:					
Earned premium revenue	\$ 74,079	(49)%	\$ 144,612	(1)%	\$ 145,749
Investment income(1)	369	(48)%	703	(14)%	817
Other income	929	(30)%	1,323	(66)%	3,897
Total revenues	75,377	(49)%	146,638	(3)%	150,463
Expenses:					
Benefits expenses	46,387	(50)%	92,135	(1)%	92,754
Underwriting and acquisition expenses(1)	26,682	(50)%	53,069	(2)%	54,389
Total expenses	73,069	(50)%	145,204	(1)%	147,143
Operating income	\$ 2,308	61%	\$ 1,434	(57)%	\$ 3,320
<i>Other operating data:</i>					
Loss ratio(2)	62.6%	(2)%	63.7%	0%	63.6%
Expense ratio(2)	36.0%	(2)%	36.7%	(2)%	37.4%
Combined health ratio	98.6%	(2)%	100.4%	(1)%	101.0%
Operating margin(3)	3.1%	210%	1.0%	(57)%	2.3%

(1) Allocations of investment income and certain general expenses are based on a number of assumptions and estimates, and the business division's reported operating results would change if different methods were applied.

(2) The health loss ratio represents benefits, claims and settlement expenses related to health insurance policies stated as a percentage of earned health premiums. The health expense ratio represents underwriting expenses, policy acquisition costs and insurance expenses related to health insurance policies stated as a percentage of earned health premiums.

(3) Operating margin is defined as operating income as a percentage of earned premium revenue.

(4) The Star HRG Division was sold on July 11, 2006. Except for some minor transition expenses recorded after July 1, 2006, the 2006 results represent six months of activity.

The Company's Star HRG Division reported operating income in 2006 in the amount of \$2.3 million, compared to operating income of \$1.4 million in 2005. The loss ratio associated with the Star HRG business decreased slightly to 62.6% in 2006 from 63.7% in 2005, and the underwriting and acquisition expense ratio decreased slightly to 36.0% in 2006 from 36.7% in 2005 from initiatives established in the fourth quarter of 2005. Earned premium revenue at the Star HRG Division was \$74.1 million in 2006, compared to \$144.6 million in 2005, reflecting the sale of the division effective July 11, 2006.

Discontinued Operations

The Company reported income from discontinued operations in 2006 in the amount of \$21.2 million, net of tax (\$0.59 per diluted share) compared to income from discontinued operations of \$531,000, net of tax (\$0.01 per diluted share) in 2005. The income for the year ended December 31, 2006 consisted primarily of a tax benefit attributable to the release of certain tax reserves and valuation allowances on deferred tax assets related to capital loss carryovers and other capital items that are currently recoverable as a result of the sale of the Star HRG Division at a gain. A significant portion of the released tax allowances and reserves were originally established during 2003

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primarily because management did not anticipate realizing before its expiration the tax benefits of the capital loss carryover from the 2003 sale of the Company's former student finance subsidiary.

2005 Compared to 2004

HealthMarkets reported revenues and income from continuing operations in 2005 of \$2.121 billion and \$203.0 million (\$4.31 per diluted share), respectively, compared to 2004 revenues and income from continuing operations of \$2.069 billion and \$145.9 million (\$3.07 per diluted share), respectively. Reflecting results from discontinued operations, the Company reported overall 2005 net income of \$203.5 million (\$4.32 per diluted share), compared to 2004 net income of \$161.6 million (\$3.40 per diluted share).

Unless the context indicates otherwise, the following discussion comparative of our 2005 and 2004 results of operations excludes the operations of the Company's Star HRG Division and Student Insurance Division which were sold in July and December 2006, respectively.

Continuing Operations

Revenues. HealthMarkets' revenues increased to \$1.684 billion in 2005 from \$1.612 billion in 2004, an increase of \$71.9 million, or 4%. The Company's revenues were particularly impacted by the following factors:

The Company generated a 4% increase in health premium revenue (to \$1.429 billion in 2005 from \$1.370 billion in 2004), which increase was primarily attributable to the assumption of existing health policies acquired in October 2004 as part of the acquisition by the Company of substantially all of the assets of HealthMarket Inc.

Life premiums and other considerations increased by 34%, to \$61.6 million in 2005 from \$45.9 million in 2004. This increase was attributable primarily to sales of newly-designed life products through its relationships with its two independent marketing companies.

Due to a 6% year over year increase in the book value of invested assets and an increase in the yield on short-term and other investments, investment income increased to \$91.0 million in 2005 compared to \$79.0 million in 2004.

Other income (consisting primarily of income derived by the SEA Division from ancillary services and membership marketing and administrative services provided to the membership associations that make available to their members the Company's health insurance products) decreased by 6% to \$103.6 million in 2005 from \$110.7 million in 2004. The decrease was primarily related to a year over year decrease in new business for which the Company receives membership marketing and administrative fees.

The Company recognized losses on sale of investments of \$(760,000) in 2005 compared to gains on sales of investments of \$6.7 million in 2004. The 2005 losses were primarily attributable to the impairment of certain fixed maturities written down in the fourth quarter of 2005.

Expenses. HealthMarkets' total expenses increased to \$1.364 billion in 2005 from \$1.345 billion in 2004, an increase of \$18.6 million, or 1%. The Company's expenses were particularly impacted by the following factors:

Benefits, claims and settlement expenses increased nominally to \$777.7 million in 2005 from \$776.5 million in 2004.

Underwriting costs, policy acquisition costs and insurance expenses increased by 2% to \$491.5 million in 2005 from \$481.3 million in 2004. The increase was primarily due to the expenses incurred with the increased new sales at both the Life Insurance Division and ZON Re.

The Company maintains for the benefit of its employees and independent agents various stock-based compensation plans, in connection with which it records non-cash variable stock-based compensation expense (benefit) in amounts that depend and fluctuate based upon the performance of the Company's common stock. In 2005, the Company recognized a non-cash stock based compensation expense in the amount of \$7.2 million, compared to non-cash stock based compensation expense of \$14.3 million in 2004. The decrease is principally due to the smaller change in share price during 2005 (from \$33.90 to \$35.51)

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compared to 2004 (from \$13.28 to \$33.90) and a decrease in the amount of unvested credits to 1,571,952 from 1,904,526.

Other expenses (consisting primarily of direct expenses incurred by the Company in connection with providing ancillary services and membership marketing and administrative services provided to the membership associations that make available to their members the Company's health insurance products and general expenses relating to corporate operations) increased by 17%, to \$81.2 million in 2005 from \$69.6 million in 2004. The majority of the increase is attributed to incremental costs in the amount of \$9.1 million associated with the then pending acquisition of the Company by a group of private equity investors.

Total interest expense increased by 76%, to \$6.0 million in 2005 from \$3.4 million in 2004, primarily due to an increase in the interest rates associated with student loan indebtedness (consisting of borrowings incurred to fund student loan obligations under the Company's College Fund Life Division program *see* Note J of Notes to Consolidated Financial Statements).

Operating Income. Operating income increased by 20%, to \$320.6 million in 2005 from \$267.3 million in 2004. As discussed more fully below, the Company's 2005 results from continuing operations benefited from a significant year-over-year increase in operating income at its SEA Division (from \$260.7 million in 2004 to \$310.5 million in 2005).

Self-Employed Agency Division

For 2005, the SEA Division reported operating income of \$310.5 million compared to operating income of \$260.7 million in 2004. Operating income at the SEA Division as a percentage of earned premium revenue (*i.e.*, operating margin) in 2005 was 22.3% compared to 19.2% in 2004.

Operating income at the SEA Division in 2005 was positively impacted by an increase in earned premium revenue, a lower loss ratio (from 54.4% in 2004 to 51.5% in 2005) resulting from favorable claims experience, and a decrease in commission expenses as a percentage of earned premium. Earned premium revenue at the SEA Division increased to \$1.395 billion in 2005, compared to earned premium revenue of \$1.355 billion in 2004. However, the increase in premium is primarily attributable to the assumption during the fourth quarter of 2004 of small group policies originally issued by a wholly owned insurance subsidiary of HealthMarket Inc. (The Company acquired substantially all of the operating assets of HealthMarket Inc. on October 8, 2004 *see* Note C of Notes to Consolidated Financial Statements). During 2005, the premium from the traditional health products issued by the SEA Division decreased approximately 1% due to the decline in submitted annualized premium volume.

Results at the SEA Division in both 2004 and 2005 reflected an aggregate benefit attributable to refinements of the Company's estimate for its claim liability on its health insurance products. Results at the SEA Division in 2004 reflected a benefit associated with the reduction in the amount of \$47.8 million of claim liabilities established in 2003 in response to a rapid pay down in 2003 of an excess pending claims inventory. In 2005, the Company recognized an aggregate benefit attributable to refinements of the Company's estimate for its claim liability on its health insurance products in the amount of \$40.9 million, of which \$7.6 million was recorded in the first quarter of 2005 and \$33.3 million was recorded in the third quarter of 2005.

In the first quarter of 2005, the Company recorded a favorable claim liability adjustment in the amount of \$7.6 million attributable to a refinement of an estimate for the Company's claim liability established with respect to a product rider that provides for catastrophic coverage on the SEA Division's scheduled health insurance products. *See* discussion below under the caption *Change in Claims and Future Benefit Liability Estimates - Self-Employed Agency Division* for additional information with respect to this adjustment.

In the third quarter of 2005, the Company recorded an additional favorable claim liability adjustment in the amount of \$33.3 million attributable to a refinement of the Company's estimate for its claim liability on its health insurance products. The largest portion of this adjustment (approximately \$21.0 million) was attributable to a refinement of the estimate of the unpaid claim liability for the most recent incurral months. The Company utilizes anticipated loss ratios to calculate the estimated claim liability for the most recent incurral months. Despite negligible premium rate increases implemented on its most popular

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scheduled health insurance products, the SEA Division has continued to observe favorable claims experience and, as a result, loss ratios have not increased as rapidly as anticipated. This favorable claims experience has been reflected in the refinement of the anticipated loss ratios used in estimating the unpaid claim liability for the most recent incurral months. The remaining portion of the adjustment to the claim liability (approximately \$12.3 million) was attributable to an update of the completion factors used in the developmental method of estimating the unpaid claim liability to reflect more current claims administration practices.

As a result of the favorable claims experience in 2005 associated with the SEA Division's health insurance products, during the fourth quarter of 2005 the Company implemented reduced premium rates (average 15% reduction) on new business in a number of markets.

The increase in operating margin in 2005 compared to 2004 was attributable primarily to the year-over-year increase in earned premium, lower loss ratio and a decrease in the effective commission rate (due to a decrease in the amount of first year premium relative to renewal premium, which carries a lower commission rate compared to commissions on first year premium). These factors favorably impacting operating margin in 2005 were offset by higher administrative expenses as a percentage of premium (which resulted from certain administrative costs associated with the previously announced multi-state market conduct review) and incremental administrative costs associated with the Company's small group business acquired in November 2004.

In 2005, total SEA Division submitted annualized premium volume decreased by 16.3%, to \$720.4 million in 2005 from \$860.4 million in 2004. The decrease in submitted annualized premium volume can be attributed primarily to a reduction in the average number of writing agents per week in the field (from 2,329 in 2004 to 2,039 in 2005).

Life Insurance Division

The Company's Life Insurance Division reported operating income in 2005 of \$7.1 million compared to operating income of \$4.7 million in 2004. The year-over-year increase in operating income was attributable to an increase in revenue and a decrease in fixed administrative costs as a percentage of earned premium revenue.

For the year ended December 31, 2005, the Company's Life Insurance Division generated annualized paid premium volume (*i.e.*, the aggregate annualized life premium amount associated with new life insurance policies issued by the Company) in the amount of \$32.9 million compared to \$32.7 million in the corresponding 2004 period. Annualized paid premium volume for the fourth quarter of 2005 was negatively impacted by a slowdown in agent recruitment by the two independent marketing companies that distribute our products through networks of managing general agents (MGAs), who were waiting for the 2006 introduction of new life products.

Other Insurance

During 2003, through a newly formed company, ZON Re USA LLC (an 82.5%-owned subsidiary), we began to underwrite, administer and issue accidental death, accidental death and dismemberment (AD&D), accident medical and accident disability insurance products, both on a primary and on a reinsurance basis. In 2005, ZON Re generated revenues and operating income of \$34.8 million and \$4.7 million, respectively, compared to revenues and operating income of \$14.4 million and \$1.4 million, respectively, in 2004.

Other Key Factors

The Company's Other Key Factors segment includes investment income not otherwise allocated to the Insurance segment, realized gains and losses, interest expense on corporate debt, variable stock compensation and other unallocated items and general expenses relating to corporate operations. In 2005, the incremental costs associated with

the pending acquisition of the Company by a group of private equity investors were also reflected in the results of the Other Key Factors segment.

The Company's Other Key Factors segment reported operating losses of \$(1.6) million in 2005, compared to operating income of \$461,000 in 2004. The increase in operating losses in 2005 in the Other Key Factors segment was primarily attributable to a decrease in net realized gains associated with the Company's investment portfolio

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(from \$7.6 million in net realized gains in 2004 to \$(760,000) in net realized losses in 2005), an increase in general corporate expenses of \$6.3 million and incremental costs in the amount of \$9.1 million associated with the pending acquisition of the Company by a group of private equity investors. These unfavorable factors were partially offset by a \$14.7 million increase in investment income on equity and a \$7.1 million year-over-year decrease in variable stock-based compensation expense associated with the various stock accumulation plans established by the Company for the benefit of its independent agents (from \$14.3 million in 2004 to \$7.2 million in 2005).

Disposed Operations

The Company's Student Insurance Division (which until its disposition by the Company in December 2006 offered tailored health insurance programs that generally provide single school year coverage to individual students at colleges and universities) reported operating losses of \$(8.9) million in 2005 compared to operating losses of \$(49.5) million in 2004. Results for 2005 at the Student Insurance Division reflected a significant improvement in loss experience on the Student Insurance book of business. The loss ratio decreased to 78.7% in 2005, from 89.4% in 2004. For 2005, operating results also benefited from lower administrative expenses as a percentage of earned premium and from better utilization of network service agreements with healthcare providers. Results in 2004 also reflected a second quarter impairment charge in the amount of \$6.3 million, which was principally associated with the abandonment of computer hardware and software assets associated with a claims processing system. Earned premium revenue at the Student Insurance Division decreased to \$282.5 million in 2005, from \$297.0 million in 2004. The decrease in premium reflected, in part, the non-renewal in the 2005-2006 school year of certain accounts that had performed poorly in the 2004-2005 school year.

The Company's former Star HRG Division reported operating income in 2005 in the amount of \$1.4 million, compared to operating income of \$3.3 million in 2004. The loss ratio associated with the Star HRG business increased slightly to 63.7% in 2005 from 63.6% in 2004, and the underwriting and acquisition expense ratio decreased slightly to 36.7% in 2005 from 37.4% in 2004. The decrease in Other income from 2004 to 2005 was associated with the decrease in administrative fees on business underwritten by a third party insurance carrier and a decrease in fees received on ancillary products. Earned premium revenue at the Star HRG Division was \$144.6 million in 2005, compared to \$145.7 million in 2004.

Discontinued Operations

The Company reported income from discontinued operations in 2005 the amount of \$531,000, net of tax (\$0.01 per diluted share) compared to income from discontinued operations of \$15.7 million, net of tax (\$0.33 per diluted share) in 2004.

Results from discontinued operations for 2004 reflected a pre-tax gain in the amount of \$7.7 million generated from the sale of the remaining uninsured student loan assets held by the Company's former Academic Management Services Corp. subsidiary (which the Company disposed of in November 2003), and a favorable resolution of a dispute related to the Company's former Special Risk Division that resulted in pre-tax income in the amount of \$10.7 million.

Variable Stock-Based Compensation

The Company sponsors a series of stock accumulation plans established for the benefit of the independent insurance agents and independent sales representatives associated with its independent agent field forces, including UGA Association Field Services and Cornerstone America. In connection with these plans, the Company has from time to time recorded and will continue to record non-cash variable stock-based compensation expense in amounts that depend and fluctuate based upon the fair value of the Company's common stock. For financial reporting purposes, the Company reflects all non-cash variable stock based compensation associated with its agent stock plans in its Other

Key Factors business segment. *See* Note Q of Notes to Consolidated Financial Statements.

The accounting treatment of the Company's agent plans has resulted and will continue to result in unpredictable non-cash stock-based compensation charges, primarily dependent upon future fluctuations in the prevailing fair value of HealthMarkets common stock. These unpredictable fluctuations in stock based compensation charges may result in material non-cash fluctuations in the Company's results of operations. Unvested benefits

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under the agent plans vest in January of each year; accordingly, in periods of general appreciation in the price of HealthMarkets common stock, the Company's cumulative liability, and corresponding charge to income, for unvested stock-based compensation is expected to be greater in each successive quarter during any given year.

Change in Claims and Future Benefit Liability Estimates Self-Employed Agency Division

2006 Change in Claim Liability Estimates

Results for the year ended December 31, 2006, reflected a benefit in the amount of \$47.1 million attributable to refinements of the Company's estimate for its claim liability on its health insurance products. For financial reporting purposes, these refinements are considered to be changes in estimate, resulting from additional information and subsequent developments from prior periods. Accordingly, the financial impact of these refinements was accounted for in the respective periods that the refinements occurred. Of the \$47.1 million of refinements to the estimated claim liability, \$44.5 million is attributable to prior years. The refinements to the estimate for the Company's claim liability are more particularly described below:

Approximately \$11.2 million of the benefit (recorded in the third quarter) was due to refinements of the estimate of the unpaid claim liability for the most recent incurrence months. The calculation of the claim liability now distinguishes between more mature products with reliable historical data and newer or lower volume products that have not established a reliable historical trend. Had this refinement been made at December 31, 2005, the claim liability estimate would have been reduced by \$14.8 million.

An additional adjustment to the claim liability (approximately \$25.1 million of which \$10.5 million was recorded in the third quarter and \$14.6 million was recorded in the fourth quarter) was attributable to an update of the completion factors used in estimating the claim liability for the Accumulated Covered Expense (ACE) rider, an optional benefit rider available with certain scheduled/basic health insurance products that provides for catastrophic coverage for covered expenses under the contract that generally exceed \$100,000 or, in certain cases, \$75,000. This rider pays benefits at 100% after the stop loss amount is reached up to the aggregate maximum amount of the contract for expenses covered by the rider. This adjustment reflects both actual historical data for the ACE rider and historical data derived from other products. In 2005, the completion factors were calculated with more emphasis placed on historical data derived from other products since there was insufficient data related to the ACE product rider to provide accurate and reliable completion factors. Had these refinements been made at December 31, 2005, the claim liability estimate would have been reduced by \$19.1 million.

In the second quarter of 2006, the Company determined that sufficient provision for large claims could be made within its normal reserve process, eliminating the need for a previously-established separate large claim reserve. This refinement resulted in a reduction in the claim liability of \$10.8 million. Had this refinement been made at December 31, 2005, the claim liability estimate would have been reduced by \$10.6 million.

2005 Change in Claim Liability Estimates

Results at the SEA Division in 2005 reflected an aggregate benefit in the amount of \$40.9 million attributable to refinements of the Company's estimate for its claim liability on its health insurance products. For financial reporting purposes, each of these refinements is considered to be a change in estimate, resulting from additional information and subsequent developments from prior periods. Accordingly, the financial impact of the refinements was accounted for in the respective periods that the refinements occurred.

Results at the SEA Division for the year ended December 31, 2005 reflected a benefit in the amount of \$33.3 million recorded in the third quarter of 2005 attributable to a refinement of the Company's estimate for its claim liability on its health insurance products. The largest portion of the adjustment (approximately \$21.0 million) was attributable to a refinement of the estimate of the unpaid claim liability for the most recent incurral months. The Company utilizes anticipated loss ratios to calculate the estimated claim liability for the most recent incurral months. Despite negligible premium rate increases implemented on its most popular scheduled health insurance products, the SEA Division has continued to observe favorable claims experience and, as a result, loss ratios have

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not increased as rapidly as anticipated. This favorable claims experience has been reflected in the refinement of the anticipated loss ratios used in estimating the unpaid claim liability for the most recent incurral months. The remaining portion of the adjustment to the claim liability (approximately \$12.3 million) was attributable to an update of the completion factors used in the developmental method of estimating the unpaid claim liability to reflect more current claims administration practices.

In addition, effective January 1, 2005, the Company's SEA Division made certain refinements to its claim liability calculations related to the ACE rider, the effect of which decreased claim liabilities and correspondingly increased operating income in the amount of \$7.6 million in the first quarter of 2005. Prior to January 1, 2005, the SEA Division utilized a technique that is commonly used to estimate claims liabilities with respect to developing blocks of business, until sufficient experience is obtained to allow more precise estimates. The Company believed that the technique produced appropriate reserve estimates in all prior periods. During the first quarter of 2005, the Company believed that there were sufficient claims paid on this benefit to produce a reserve estimate utilizing the completion factor technique. As a result, effective January 1, 2005, the SEA Division refined its technique used to estimate claim liabilities to utilize completion factors for older incurral dates. The technique continues to utilize anticipated loss ratios in the most recent incurral months. This completion factor technique utilized historical data derived from other products since there was insufficient data related to the ACE product rider to provide accurate and reliable completion factors.

Table of Contents**Quarterly Results**

The following table presents the information for each of the Company's fiscal quarters in 2006 and 2005. This information is unaudited and has been prepared on the same basis as the audited Consolidated Financial Statements of the Company included herein and, in management's opinion, reflects all adjustments necessary for a fair presentation of the information for the periods presented. The Company has elected to utilize the one time special transition provisions of SAB 108 and recorded an adjustment to retained earnings effective January 1, 2006 to reflect this change in accounting policy with respect to the capitalization and amortization of deferred acquisition costs associated with excess first and second year commissions. As of January 1, 2006, the change in accounting policy resulted in an increase in the Company's capitalized deferred acquisition cost (DAC) of \$77.6 million, a related increase to its deferred tax liability by \$27.1 million, and a net increase to shareholders' equity of \$50.5 million. The adoption of this new accounting policy had the effect of increasing reported underwriting, policy acquisition costs and insurance expenses (classified to its SEA Division) in 2006 by the amount of \$15.5 million and, correspondingly, reducing after-tax net income by \$10.1 million. The Company has reflected the effects of this change in accounting policy for the 2006 interim periods in the Quarterly Results table below. The operating results for any quarter are not necessarily indicative of results for any future period.

	Quarter Ended							
	December 31,	September 30,	June 30,	March 31,	December 31,	September 30,	June 30,	March 31,
	2006	2006	2006	2006	2005	2005	2005	2005

(In thousands except per share amounts)

**Income
Statement
Data:**

Revenues

from continuing operations	\$ 555,305	\$ 562,568	\$ 515,543	\$ 513,155	\$ 515,744	\$ 520,174	\$ 545,908	\$ 539,392
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Income from

continuing operations before federal income taxes	125,954	154,152	13,728	58,464	59,802	92,755	79,514	81,079
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Income from

continuing operations	82,168	89,874	5,680	38,846	37,498	60,672	52,142	52,658
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Income

(loss) from discontinued operations	507	301	19,701	661	971	373	173	(986)
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Net income	\$ 82,675	\$ 90,175	\$ 25,381	\$ 39,507	\$ 38,469	\$ 61,045	\$ 52,315	\$ 51,672
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Per Share

Data:

Basic

earnings

*(loss) per
common
share:*

Income from continuing operations	\$	2.75	\$	3.01	\$	0.17	\$	0.84	\$	0.81	\$	1.31	\$	1.13	\$	1.14
Income (loss) from discontinued operations		0.02		0.01		0.58		0.01		0.02		0.01		0.00		(0.02)
Net income	\$	2.77	\$	3.02	\$	0.75	\$	0.85	\$	0.83	\$	1.32	\$	1.13	\$	1.12

*Diluted
earnings
(loss) per
common
share:*

Income from continuing operations	\$	2.67	\$	2.94	\$	0.16	\$	0.83	\$	0.80	\$	1.29	\$	1.11	\$	1.11
Income (loss) from discontinued operations		0.02		0.01		0.57		0.01		0.02		0.01		0.00		(0.02)
Net income	\$	2.69	\$	2.95	\$	0.73	\$	0.84	\$	0.82	\$	1.30	\$	1.11	\$	1.09

Computation of earnings (loss) per share for each quarter is made independently of earnings (loss) per share for the year.

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Liquidity and Capital Resources

Consolidated

On a consolidated level, the Company's primary sources of liquidity have been premium revenues from policies issued, investment income, fees and other income, proceeds from corporate borrowings and borrowings to fund student loans. The primary uses of cash have been payments for benefits, claims and commissions under those policies, operating expenses, cash dividends to shareholders, stock repurchases and the funding of student loans. During 2006, the Company generated on a consolidated basis net cash from operations in the amount of \$42.8 million, compared to net cash from operations of \$185.4 million in 2005 and \$254.2 million in 2004. The decrease in cash flow from operations in 2006 is due to the cash used to transfer the net liabilities of the Student Insurance Division and the Star HRG Division of \$85.5 million. In addition, income from continuing operations before tax, excluding realized gains recorded on the sale of the Student Insurance Division and the Star HRG Division, decreased \$162.6 million in 2006 from 2005.

The Company's consolidated short and long-term indebtedness (exclusive of indebtedness secured by student loans) was \$556.1 million and \$15.5 million at December 31, 2006 and 2005, respectively.

In connection with the Merger, the Company borrowed \$500.0 million under a term loan credit facility and issued \$100.0 million of Floating Rate Junior Subordinated Notes. This indebtedness is more particularly described below:

In connection with the Merger completed on April 5, 2006, HealthMarkets, LLC, a direct wholly-owned subsidiary of the Company, entered into a credit agreement, providing for a \$500.0 million term loan facility and a \$75.0 million revolving credit facility (which includes a \$35.0 million letter of credit sub-facility). The full amount of the term loan was drawn at closing, and the proceeds thereof were used to fund a portion of the consideration paid in the Merger. At December 31, 2006, the Company had an aggregate of \$437.5 million of indebtedness outstanding under the term loan facility, which indebtedness bore interest at the London inter-bank offered rate (LIBOR) plus a borrowing margin (1.00%). The Company has not drawn on the \$75.0 million revolving credit facility. During the six months ended December 31, 2006, the Company made its regularly scheduled quarterly principal payment in the amount of \$2.5 million and a voluntary prepayment in the amount of \$60.0 million on the term loan facility.

The revolving credit facility will mature on April 5, 2011, and the term loan facility will mature on April 5, 2012. The term loan required nominal quarterly installments (not exceeding 0.25% of the aggregate principal amount at the date of issuance) until the maturity date, at which time the remaining principal amount is due. As a result of the \$60.0 million prepayment, the Company is not obligated to make future nominal quarterly installments as previously required by the credit agreement. Borrowings under the credit agreement may be subject to certain mandatory prepayments. At HealthMarkets, LLC's election, the interest rates per annum applicable to borrowings under the credit agreement are based on a fluctuating rate of interest measured by reference to either (a) LIBOR plus a borrowing margin, or (b) a base rate plus a borrowing margin. HealthMarkets, LLC will pay (a) fees on the unused loan commitments of the lenders, (b) letter of credit participation fees for all letters of credit issued, plus fronting fees for the letter of credit issuing bank, and (c) other customary fees in respect of the credit facility. Borrowings and other obligations under the credit agreement are secured by a pledge of HealthMarkets, LLC's interest in substantially all of its subsidiaries, including the capital stock of MEGA, Mid-West and Chesapeake.

On April 5, 2006, HealthMarkets Capital Trust I and HealthMarkets Capital Trust II (two newly formed Delaware statutory business trusts) (collectively the Trusts) issued \$100.0 million of floating rate trust preferred securities (the Trust Securities) and \$3.1 million of floating rate common securities. The Trusts invested the proceeds from the sale of the Trust Securities, together with the proceeds from the issuance to

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HealthMarkets, LLC by the Trusts of the common securities, in \$100.0 million principal amount of HealthMarkets, LLC's Floating Rate Junior Subordinated Notes due June 15, 2036 (the Notes), of which \$50.0 million principal amount accrue interest at a floating rate equal to three-month LIBOR plus 3.05% and \$50.0 million principal amount accrue interest at a fixed rate of 8.367% through but excluding June 15, 2011

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and thereafter at a floating rate equal to three-month LIBOR plus 3.05%. Distributions on the Trust Securities will be paid at the same interest rates paid on the Notes.

The Notes, which constitute the sole assets of the Trusts, are subordinate and junior in right of payment to all senior indebtedness (as defined in the Indentures) of HealthMarkets, LLC. The Company has fully and unconditionally guaranteed the payment by the Trusts of distributions and other amounts payable under the Trust Securities. The guarantee is subordinated to the same extent as the Notes. The Trusts are obligated to redeem the Trust Securities when the Notes are paid at maturity or upon any earlier prepayment of the Notes. Prior to June 15, 2011, the Notes may be redeemed only upon the occurrence of certain tax or regulatory events at 105.0% of the principal amount thereof in the first year reducing by 1.25% per year until it reaches 100.0%. On and after June 15, 2011 the Notes are redeemable, in whole or in part, at the option of the Company at 100.0% of the principal amount thereof.

On April 29, 2004, UICI Capital Trust I (a newly formed Delaware statutory business trust) (the 2004 Trust) completed the private placement of \$15.0 million aggregate issuance amount of floating rate trust preferred securities with an aggregate liquidation value of \$15.0 million (the 2004 Trust Preferred Securities). The 2004 Trust invested the \$15.0 million proceeds from the sale of the 2004 Trust Preferred Securities, together with the proceeds from the issuance to the Company by the 2004 Trust of its floating rate common securities in the amount of \$470,000 (the Common Securities and, collectively with the 2004 Trust Preferred Securities, the 2004 Trust Securities), in an equivalent face amount of the Company's Floating Rate Junior Subordinated Notes due 2034 (the 2004 Notes). The 2004 Notes will mature on April 29, 2034, which date may be accelerated to a date not earlier than April 29, 2009. The 2004 Notes may be prepaid prior to April 29, 2009, at 107.5% of the principal amount thereof, upon the occurrence of certain events, and thereafter at 100.0% of the principal amount thereof. The 2004 Notes, which constitute the sole assets of the 2004 Trust, are subordinate and junior in right of payment to all senior indebtedness (as defined in the Indenture, dated April 29, 2004, governing the terms of the 2004 Notes) of the Company. The 2004 Notes accrue interest at a floating rate equal to three-month LIBOR plus 3.50%, payable quarterly on February 15, May 15, August 15, and November 15 of each year. At December 31, 2006, the 2004 Notes bore interest at an annual rate of 8.87%. The quarterly distributions on the 2004 Trust Securities are paid at the same interest rate paid on the 2004 Notes.

At December 31, 2006 and 2005, the Company had an aggregate of \$119.0 million and \$130.9 million, respectively, of indebtedness outstanding under a secured student loan credit facility, which indebtedness is represented by Student Loan Asset-Backed Notes (the SPE Notes) issued by a bankruptcy-remote special purpose entity (the SPE). At December 31, 2006 and 2005, indebtedness outstanding under the secured student loan credit facility was secured by alternative (*i.e.*, non-federally guaranteed) student loans and accrued interest in the carrying amount of \$111.2 million and \$115.3 million, respectively, and by a pledge of cash, cash equivalents and other qualified investments in the amount of \$14.2 million and \$20.5 million, respectively. At December 31, 2006, \$7.2 million of such cash, cash equivalents and other qualified investments was available to fund the purchase from the Company of additional student loans generated under the Company's College First Alternative Loan program, which purchases may be made in accordance with the terms of the agreements governing the securitization until February 2007. After February 1, 2007, the Company will fund loans with cash on hand from HealthMarkets LLC.

All indebtedness issued under the secured student loan credit facility is reflected as student loan indebtedness on the Company's consolidated balance sheet; all such student loans and accrued investment income pledged to secure such facility are reflected as student loan assets and accrued investment income, respectively, on the Company's consolidated balance sheet; and all such cash, cash equivalents and qualified investments specifically pledged under the student loan credit facility are reflected as restricted cash on the Company's consolidated balance sheet. The SPE Notes represent obligations solely of the SPE and not of the Company or any other subsidiary of the Company. For financial reporting and accounting purposes the student loan credit facility has been classified as a financing. Accordingly, in connection with the financing the Company has recorded and will in the future record no gain on sale

of the assets transferred to the SPE.

The SPE Notes were issued by the SPE in three tranches (\$50.0 million of Series 2001A-1 Notes and \$50.0 million of Series 2001A-2 Notes issued on April 27, 2001, and \$50.0 million of Series 2002A Notes issued on April 10, 2002). The Series 2001A-1 Notes and Series 2001A-2 Notes have a final stated maturity of July 1, 2036;

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the Series 2002A Notes have a final stated maturity of July 1, 2037. However, the SPE Notes are subject to mandatory redemption in whole or in part (a) on the first interest payment date which is at least 45 days after February 1, 2007, from any monies then remaining on deposit in the acquisition fund not used to purchase additional student loans and (b) on the first interest payment date which is at least 45 days after July 1, 2005, from any monies then remaining on deposit in the acquisition fund received as a recovery of the principal amount of any student loan securing payment of the SPE Notes, including scheduled, delinquent and advance payments, payouts or prepayments. After July 1, 2005, the SPE Notes are also subject to mandatory redemption in whole or in part on each interest payment date from any monies received as a recovery of the principal amount of any student loan securing payment of the SPE Notes, including scheduled, delinquent and advance payments, payouts or prepayments. During 2006 and 2005 the Company made principal payments in the aggregate amount of \$11.9 million and \$19.1 million, respectively, on the Notes.

The SPE and the secured student loan facility were structured with an expectation that interest and recoveries of principal to be received with respect to the underlying student loans securing payment of the SPE Notes would be sufficient to pay principal of and interest on the SPE Notes when due, together with operating expenses of the SPE. This expectation was based upon analysis of cash flow projections, and assumptions regarding the timing of the financing of the underlying student loans to be held by the SPE, the future composition of and yield on the financed student loan portfolio, the rate of return on monies to be invested by the SPE in various funds and accounts established under the indenture governing the SPE Notes, and the occurrence of future events and conditions. There can be no assurance, however, that the student loans will be financed as anticipated, that interest and principal payments from the financed student loans will be received as anticipated, that the reinvestment rates assumed on the amounts in various funds and accounts will be realized, or other payments will be received in the amounts and at the times anticipated.

Holding Company

HealthMarkets Inc. is a holding company, the principal asset of which is its investment in its wholly owned subsidiary, HealthMarkets LLC (collectively referred to as *holding company* in this section). HealthMarkets LLC's principal assets are its investment in its separate operating subsidiaries, including its regulated insurance subsidiaries. The holding company's ability to fund its cash requirements is largely dependent upon its ability to access cash, by means of dividends or other means, from its subsidiaries. The laws governing the Company's insurance subsidiaries restrict dividends paid by the Company's domestic insurance subsidiaries in any year. Inability to access cash from its subsidiaries could have a material adverse effect upon the Company's liquidity and capital resources.

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At December 31, 2006 and 2005, HealthMarkets, Inc. and HealthMarkets LLC at the holding company level held cash and cash equivalents in the amount of \$311.5 million and \$151.4 million, respectively. Set forth below is a summary statement of aggregate cash flows for HealthMarkets, Inc and HealthMarkets LLC for each of the three most recent years:

	Year Ended December 31,		
	2006	2005	2004
	(In thousands)		
Cash and cash equivalents on hand at beginning of year	\$ 151,423	\$ 39,573	\$ 37,840
Sources of cash:			
Dividends from domestic insurance subsidiaries(1)	213,200	146,000	23,000
Dividends from offshore insurance subsidiaries	6,950	9,000	5,290
Dividends from non-insurance subsidiaries(2)	1,607	9,037	27,630
Debt proceeds(3)	600,000		14,570
Contribution by private equity firms	985,000		
Principal repayment on Star HRG buyer note(4)	72,365		
Proceeds from issuance of senior secured notes by non-consolidated qualifying special purpose entity(5)	71,929		
Proceeds from other financing activities(6)	27,870	12,253	26,587
Proceeds from stock option activities	337	2,582	7,524
Net tax treaty payments from subsidiaries	40,499	5,536	
Net investment activities	3,221	1,773	
Total sources of cash	2,022,978	186,181	104,601
Uses of cash:			
Cash to operations	(34,172)	(14,767)	(17,948)
Contributions/investment in subsidiaries(7)	(635)	(1,690)	(2,506)
Interest on debt	(23,808)	(1,023)	(993)
Repayment of debt	(62,500)		(18,951)
Financing activities(8)	(150)	(370)	(2,856)
Dividends paid to shareholders		(34,705)	(11,477)
Purchases of HealthMarkets common stock(9)	(8,745)	(13,359)	(36,220)
Net investment activities			(10,387)
Net tax treaty net payments from subsidiaries			(1,530)
Merger transaction costs(10)	(120,921)	(8,417)	
Treasury stock purchase in Merger(11)	(1,611,989)		
Total uses of cash	(1,862,920)	(74,331)	(102,868)
Cash and cash equivalents on hand at end of year	\$ 311,481	\$ 151,423	\$ 39,573
Cash and cash equivalents at HealthMarkets, Inc.	\$ 48,578	\$ 151,423	\$ 39,573
Cash and cash equivalents at HealthMarkets LLC	262,903		

Cash and cash equivalents on hand at end of year	\$	311,481	\$	151,423	\$	39,573
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- (1) Consists of dividends paid to the holding company by MEGA and Mid-West.
- (2) Includes in 2004 \$25.0 million of dividends from a non-insurance subsidiary related to the sale of the remaining uninsured student loans retained by the Company upon the sale of AMS.
- (3) Includes in 2006 proceeds from the term loan facility in the amount of \$500 million and proceeds from the floating rate Junior Subordinated Notes of \$100 million.

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- (4) Includes distribution from a special purpose subsidiary of the principal payment received in 2006 in the amount of \$72.4 million on the \$150.8 million promissory note received in July 2006. *See* Notes C and L of Notes to Consolidated Financial Statements.
- (5) Reflects net proceeds of issuance by a non-consolidated qualifying special purpose subsidiary of \$72.4 million principal amount of senior secured notes, which notes are secured by a pledge of the \$150.8 million promissory note received in July 2006. HealthMarkets LLC received the promissory note as a non-cash dividend from its subsidiary, MEGA, and subsequently assigned the note to the special purpose subsidiary. *See* Notes C and L of Notes to Consolidated Financial Statements.
- (6) Includes borrowings from and/or repayments on loans from subsidiaries in the amount of \$800,000, \$358,000 and \$3.9 million in 2006, 2005 and 2004, respectively, proceeds from subsidiaries related to agent stock plans in the amount of \$20.4 million, \$11.1 million and \$19.7 million in 2006, 2005 and 2004, respectively, repayment on loans from non-affiliated companies of \$3.9 million, and proceeds from the sale of Class A-1 common stock to officers and directors of \$2.8 million in 2006.
- (7) Includes purchase of and investment in non-insurance subsidiaries and funding of discontinued operations.
- (8) Includes advances to subsidiaries in the amount of \$150,000, \$370,000 and \$2.9 million in 2006, 2005, and 2004, respectively.
- (9) Includes repurchase of HealthMarkets common stock under the Company's stock repurchase program in the amount of \$-0- (-0- shares), \$7.0 million (310,900 shares) and \$16.3 million (1,043,400 shares) in 2006, 2005 and 2004, respectively. Also includes in 2006, 2005 and 2004 the amounts of \$8.7 million, \$6.4 million and \$19.9 million, respectively, representing repurchases of HealthMarkets common stock for agent stock accumulation plans and purchases from officers or employees of the Company.
- (10) Includes the costs associated with the acquisition of the Company by a group of private equity investors.
- (11) Includes the repurchase of 43,567,252 shares of HealthMarkets common stock at \$37.00 per share in connection with the Merger.

Prior approval by insurance regulatory authorities is required for the payment by a domestic insurance company of dividends that exceed certain limitations based on statutory surplus and net income. During 2007, the Company's domestic insurance companies can pay, without prior approval of the regulatory authorities, aggregate dividends in the ordinary course of business to the holding company of approximately \$71.2 million. However, as it has done in the past, the Company will assess the results of operations of the regulated domestic insurance companies to determine the prudent dividend capability of the subsidiaries, consistent with HealthMarkets' practice of maintaining risk-based capital ratios at each of the Company's domestic insurance subsidiaries significantly in excess of minimum requirements.

Sources and Uses of Cash and Liquidity

During 2006, 2005 and 2004, the Company's cash and liquidity at the holding company were positively impacted by the following significant factors and developments:

During 2006, the Company received an aggregate of \$221.7 million in cash dividends from its subsidiaries, compared to \$164.0 million of cash dividends received in 2005.

During 2006, the Company received \$10.4 million of investment income on short-term investments and other invested assets held at the holding company.

During 2006, the Company received a distribution from a special purpose subsidiary of the cash principal payment in the amount of \$72.4 million on the \$150.8 million promissory note received in July 2006 as consideration for sale of assets comprising the Company's Star HRG unit.

During 2006 the Company received net cash proceeds in the amount of \$71.9 million from the issuance by a non-consolidated qualifying special purpose subsidiary of \$72.4 million principal amount of senior secured notes.

On April 5, 2006, the Company received \$985.0 million for the purchase of common stock by the group of private equity firms in connection with the merger.

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As described above, to finance the Merger the Company utilized the proceeds of additional indebtedness incurred in April 2006 in the amount of \$600.0 million, consisting of \$500.0 million under a term loan credit facility and \$100.0 million of Floating Rate Junior Subordinated Notes.

On March 31, 2004, the Company completed the sale of all of the remaining uninsured student loan assets formerly held by the Company's former Academic Management Services Corp. subsidiary. The sale of the uninsured student loans generated gross cash proceeds in the amount of approximately \$25.0 million.

In April 2004, the Company, through a newly formed Delaware statutory business trust, generated net proceeds of \$14.6 million from the issuance in a private placement of \$15.0 million aggregate issuance amount of floating rate trust preferred securities. *See* Note I of Notes to Consolidated Financial Statements.

Effective November 1, 2004, the Company terminated a \$30.0 million bank credit facility that was otherwise scheduled to mature in January 2005. At the time the facility was terminated, the Company had no borrowings outstanding under the facility.

During 2006, 2005 and 2004, the Company's principal uses of cash and liquidity at the holding company were as follows:

During 2006 and 2005, the holding company expended significant amounts of cash for expenses related to the Merger, of which approximately \$120.9 million was expended during 2006 and approximately \$8.4 million was expended during the fourth quarter of 2005.

On April 5, 2006, the Company utilized \$1.6 billion to repurchase 43,567,252 shares of its common stock in the Merger.

During 2006, the holding company paid interest and principal on its \$500.0 million term loan facility in the amount of \$16.4 million and \$62.5 million, respectively. The Company's \$62.5 million repayment of principal on the facility included a voluntary prepayment in the amount of \$60.0 million.

In April 2005, HealthMarkets utilized approximately \$7.0 million to repurchase 310,900 shares of its common stock pursuant to its share repurchase program. During 2004, HealthMarkets utilized approximately \$16.3 million to repurchase 1,043,400 of its common stock pursuant to its share repurchase program. Such amounts are reflected as Purchases of HealthMarkets common stock in the table above.

During 2005 and 2004, the Company paid aggregate dividends to holders of its common stock in the amount of \$34.7 million and \$11.5 million, respectively. On August 18, 2004, the Company's Board of Directors adopted a policy of issuing a regular semi-annual cash dividend on shares of its common stock. Dividends paid in 2005 also included a \$0.25 per share special dividend (\$11.6 million in the aggregate) paid in March 2005. Since the execution on September 15, 2005 of a definitive agreement contemplating the acquisition of the Company in a cash merger by a group of private equity firms, the Company has not declared or paid additional dividends on shares of its common stock.

In April 2004, the Company paid in full its outstanding 6% convertible subordinated notes in the aggregate amount of \$15.0 million and accrued interest thereon to the date of prepayment. The notes had been issued by the Company in November 2003 in full payment of all contingent consideration payable in connection with HealthMarkets' February 2002 acquisition of Star HRG.

In June 2004, the Company paid in full the final payment due in the amount of \$4.0 million on its 8.75% Senior Notes due June 2004, which the Company had issued in 1994 in the original aggregate issuance amount of \$27.7 million.

Table of Contents**Contractual Obligations and Off Balance Sheet Arrangements**

Set forth below is a summary of the Company's contractual obligations (on a consolidated basis) at December 31, 2006:

	Total	Payment Due by Period			More Than 5 Years
		Less Than 1 Year	1-3 Years	3-5 Years	
		(In thousands)			
Corporate debt	\$ 556,070	\$	\$	\$	\$ 556,070
Student loan credit facility(1)	118,950	18,050	28,550	25,450	46,900
Future policy benefits(2)	453,715	21,103	47,407	40,408	344,797
Claim liabilities(2)	517,132	418,412	90,069	5,176	3,475
Capital lease obligations	1,709	1,325	384		
Operating lease obligations	10,690	3,775	5,404	1,511	
Total	\$ 1,658,266	\$ 462,665	\$ 171,814	\$ 72,545	\$ 951,242

- (1) All indebtedness issued under the secured student loan credit facility represent obligations solely of the SPE and not of the Company or any other subsidiary and is secured by student loans, accrued investment income, cash, cash equivalents and qualified investments.
- (2) The payments related to the future policy benefits and claim liabilities reflected in the table above have been projected utilizing assumptions based on the Company's historical experience and anticipated future experience.

The Company's off balance sheet arrangements consist of commitments to fund student loans generated by its former College Fund Life Division and letters of credit.

Through the Company's former College Fund Life Division, the Company previously offered an interest-sensitive whole life insurance product issued with a child term rider, under which the Company committed to provide private student loans to help fund the named child's higher education if certain restrictions and qualifications are satisfied. At December 31, 2006, the Company had outstanding commitments to fund student loans under the College Fund Life Division program for the years 2007 through 2025. Loans are limited to the cost of school or prescribed maximums. These loans are generally guaranteed as to principal and interest by a private guarantee agency and are also collateralized by either the related insurance policy or the co-signature of a parent or guardian. The total student loan funding commitments for each of the next five school years and thereafter, as well as the amount the Company expects to be required to fund based on historical utilization rates and policy lapse rates, are as follows as of December 31, 2006:

Total Commitment	Expected Funding
(In thousands)	

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2007	\$ 35,903	\$ 3,364
2008	30,427	2,913
2009	27,302	2,518
2010	28,758	2,246
2011	32,144	1,981
2012 and thereafter	115,276	3,826
Total	\$ 269,810	\$ 16,848

Interest rates on the above commitments are principally variable (prime plus 2%).

Through February 1, 2007, the Company has funded its College Fund Life Division student loan commitments with the proceeds of indebtedness issued by a bankruptcy-remote special purpose entity (the SPE Notes). The indenture governing the terms of the SPE Notes provided that the proceeds of such SPE Notes could be used to fund

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student loan commitments only until February 1, 2007, after which any monies then remaining on deposit in the acquisition fund created by the indenture not used to purchase additional student loans are required to be used to redeem the SPE Notes. After February 1, 2007, the Company will fund loans with cash on hand from HealthMarkets LLC. During 2006, principal payments on the Notes were made in the amount of \$12.0 million from the proceeds from the repayment on the student loan receivables. *See* discussion above under the caption Liquidity and Capital Resources *Consolidated* and Note J of Notes to Consolidated Financial Statements.

At each of December 31, 2006 and 2005, the Company had \$9.6 million and \$5.2 million, respectively, of letters of credit outstanding relating to its insurance operations.

Investments

The Company's Investment Committee monitors the investment portfolio of the Company and its subsidiaries. The Investment Committee receives investment management services from external professionals and from the Company's in-house investment management team. The internal investment management team monitors the performance of the external managers as well as directly managing approximately 71% of the investment portfolio.

Investments are selected based upon the parameters established in the Company's investment policies. Emphasis is given to the selection of high quality, liquid securities that provide current investment returns. Maturities or liquidity characteristics of the securities are managed by continually structuring the duration of the investment portfolio to be consistent with the duration of the policy liabilities. Consistent with regulatory requirements and internal guidelines, the Company invests in a range of assets, but limits its investments in certain classes of assets, and limits its exposure to certain industries and to single issuers.

Investments are reviewed quarterly (or more frequently if certain indicators arise) to determine if they have suffered an impairment of value that is considered other than temporary. Management's review considers the following indicators of impairment: fair value significantly below cost; decline in fair value attributable to specific adverse conditions affecting a particular investment; decline in fair value attributable to specific conditions, such as conditions in an industry or in a geographic area; decline in fair value for an extended period of time; downgrades by rating agencies from investment grade to non-investment grade; financial condition deterioration of the issuer and situations where dividends have been reduced or eliminated or scheduled interest payments have not been made. Management monitors investments where two or more of the above indicators exist. The Company also identifies investments in economically challenged industries. If investments are determined to be impaired, a loss is recognized at the date of determination.

Set forth below is a summary of the Company's investments by category at December 31, 2006 and 2005:

	December 31, 2006		December 31, 2005	
	Carrying Amount	% of Total Carrying Value (Dollars in thousands)	Carrying Amount	% of Total Carrying Value
Securities available for sale				
Fixed maturities, at fair value (cost: 2006				
\$1,391,275; 2005 \$1,496,340)	\$ 1,374,403	76.3%	\$ 1,484,465	83.5%

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Equity securities, at fair value (cost: 2006	\$283;				
2005 \$1,508)		318	0.3%	1,347	0.1%
Mortgage loans			0.0%	751	0.0%
Policy loans		14,625	0.8%	16,325	0.9%
Short-term and other investments		412,498	22.9%	275,036	15.5%
Total investments		\$ 1,801,844	100.0%	\$ 1,777,924	100.0%

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Fixed maturity securities represented 76.3% and 83.5% of the Company's total investments at December 31, 2006 and 2005, respectively. Fixed maturity securities at December 31, 2006 consisted of the following:

	December 31, 2006	
	Carrying Value (Dollars in thousands)	% of Total Carrying Value
U.S. Treasury and U.S. Government agency obligations	\$ 73,283	5.3%
Corporate bonds	912,577	66.4%
Mortgage-backed securities issued by U.S. Government agencies and authorities	225,400	16.4%
Other mortgage and asset backed securities	158,306	11.5%
Other	4,837	0.4%
Total fixed maturity securities	\$ 1,374,403	100.0%

Corporate bonds included in the fixed maturity portfolio consist primarily of short term and medium term investment grade bonds. The Company's investment policy with respect to concentration risk limits individual investment grade bonds to 3% of assets and non-investment grade bonds to 2% of assets. The policy also limits the investments in any one industry to 20% of assets. As of December 31, 2006, the largest concentration in any one investment grade corporate bond was \$94.8 million, which represented 5.3% of total invested assets. This security was received as payment on the sale of the Student Division. To limit its credit risk, the Company has taken out \$75.0 million of credit default insurance on this bond, reducing its default exposure to \$19.8 million, or 1.1% of total invested assets. The largest concentration in any one non-investment grade corporate bond was \$3.5 million, which represented less than 1% of total invested assets. The largest concentration to any one industry was less than 10%.

Included in the fixed maturity portfolio are mortgage-backed securities, including collateralized mortgage obligations, mortgage-backed pass-through certificates, and commercial mortgage-backed securities. To limit its credit risk, the Company invests in mortgage-backed securities that are rated investment grade by the public rating agencies. The Company's mortgage-backed securities portfolio is a conservatively structured portfolio that is concentrated in the less volatile tranches, such as planned amortization classes and sequential classes. The Company seeks to minimize prepayment risk during periods of declining interest rates and minimize duration extension risk during periods of rising interest rates. The Company has less than 1% of its investment portfolio invested in the more volatile tranches.

As of December 31, 2006 and 2005, \$1.356 billion or (98.7%) and \$1.457 billion (or 98.1%), respectively, of the fixed maturity securities portfolio was rated BBB or better (investment grade), and \$18.2 million or (1.3%) and \$27.6 million (or 1.9%), respectively, of the fixed maturity securities portfolio was invested in below investment grade securities (rated less than BBB).

A quality distribution for fixed maturity securities at December 31, 2006 is set forth below:

**December 31,
2006**
% of Total

Rating	Carrying Value (Dollars in thousands)	Carrying Value
U.S. Government and AAA	\$ 593,601	43.2%
AA	155,928	11.3%
A	460,225	33.5%
BBB	146,488	10.7%
Less than BBB	18,161	1.3%
	\$ 1,374,403	100.0%

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The Company has classified its entire fixed maturity portfolio as available for sale. This classification requires the portfolio to be carried at fair value with the resulting unrealized gains or losses, net of applicable income taxes, reported in accumulated other comprehensive income as a separate component of stockholders' equity. As a result, fluctuations in fair value, which is affected by changes in interest rates, will result in increases or decreases to the Company's stockholders' equity.

During 2006, 2005 and 2004, the Company recorded impairment charges for certain fixed and equity securities in the amount of \$2.4 million, \$4.1 million and \$3.6 million, respectively.

Set forth below is a summary of the Company's gross unrealized losses in its portfolio of fixed maturity securities as of December 31, 2006:

Description of Securities	Unrealized Loss Less Than 12 Months		Unrealized Loss 12 Months or Longer		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
			(In thousands)			
U.S. Treasury obligations and direct obligations of U.S. Government agencies	\$ 20,353	\$ 75	\$ 36,149	\$ 651	\$ 56,502	\$ 726
Mortgage backed securities issued by U.S. Government agencies and authorities	26,399	143	179,551	4,667	205,950	4,810
Other mortgage and asset backed securities	38,250	176	111,058	3,028	149,308	3,204
Corporate bonds	77,682	444	343,231	15,522	420,913	15,966
Other	4,837	2,162			4,837	2,162
Total	\$ 167,521	\$ 3,000	\$ 669,989	\$ 23,868	\$ 837,510	\$ 26,868

At December 31, 2006, the Company had \$26.9 million of unrealized losses in its fixed maturities portfolio. Of the \$3.0 million in unrealized losses that have existed for less than twelve months, all but a single security have unrealized losses of less than 2% of cost. The single security (which consists of the Company's residual interest in Grapevine Finance LLC and which has been classified as "Other" in the table above) had at December 31, 2006 an unrealized loss of \$2.2 million, or 30.9% of cost. See Notes C and L of Notes to Consolidated Financial Statements. The Company believes that the cash flows received from the security have not changed from those that were expected when the securitization was completed in 2006. Of the \$23.9 million in unrealized losses that have existed for twelve months or longer, eight securities had an unrealized loss in excess of 10% of the security's cost. The amount of unrealized loss with respect to those securities was \$4.9 million at December 31, 2006. The Company continually monitors these investments and believes that, as of December 31, 2006, the unrealized loss in these investments is temporary.

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Set forth below is a summary of the Company's gross unrealized losses in its fixed maturities as of December 31, 2005:

Description of Securities	Unrealized Loss Less Than 12 Months		Unrealized Loss 12 Months or Longer		Total	
	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
U.S. Treasury obligations and direct obligations of U.S. Government agencies	\$ 61,872	\$ 747	\$ 13,632	\$ 390	\$ 75,504	\$ 1,137
Mortgage backed securities issued by U.S. Government agencies and authorities	145,168	2,077	68,632	2,124	213,800	4,201
Other mortgage and asset backed securities	67,635	947	78,020	2,618	145,655	3,565
Corporate bonds	380,079	7,642	260,044	10,180	640,123	17,822
Total	\$ 654,754	\$ 11,413	\$ 420,328	\$ 15,312	\$ 1,075,082	\$ 26,725

The Company regularly monitors its investment portfolio to attempt to minimize its concentration of credit risk in any single issuer. Set forth in the table below is a schedule of all investments representing greater than 1% of the Company's aggregate investment portfolio at December 31, 2006 and 2005, excluding investments in U.S. Government securities:

Issuer	December 31,			
	2006	% of Total Carrying Amount	2005	% of Total Carrying Amount
<i>Issuer - Fixed Maturities:</i>				
UnitedHealth Group(1)	\$ 94,763	5.3%	\$	%
Federal National Mortgage Corporation	17,992	1.0%	25,370	1.4%
<i>Issuer - Short-term investments:</i>				
Fidelity Institutional Money Market Fund(2)	\$ 325,677	18.1%	\$ 200,900	11.3%

- (1) Represents security received from the purchaser as consideration upon sale of the Company's former Student Insurance Division on December 1, 2006. To reduce the Company's credit risk, the Company has taken out \$75.0 million of credit default insurance on this security, reducing the Company's default exposure to \$19.8 million. See Note C of Notes to Consolidated Financial Statements.

- (2) The Fidelity Institutional Money Market Fund is a diversified institutional money market fund that invests solely in high quality United States dollar denominated money market securities of domestic and foreign issuers.

Critical Accounting Policies and Estimates

The Company's discussion and analysis of its financial condition and results of operations are based upon the Company's consolidated financial statements, which have been prepared in accordance with accounting principles generally accepted in the United States of America. The preparation of these financial statements requires the Company to make estimates and judgments that affect the reported amounts of assets, liabilities, revenues and expenses, and related disclosure of contingent assets and liabilities. On an on-going basis, the Company evaluates its estimates, including those related to health and life insurance claims, bad debts, investments, intangible assets, income taxes, financing operations and contingencies and litigation. The Company bases its estimates on historical experience and on various other assumptions that are believed to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of assets and liabilities that are not readily

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apparent from other sources. Actual results may differ from these estimates under different assumptions or conditions.

The Company believes the following critical accounting policies affect its more significant judgments and estimates used in the preparation of its consolidated financial statements.

Claims Liabilities

The Company establishes liabilities for benefit claims that have been reported but not paid and claims that have been incurred but not reported under health and life insurance contracts. Consistent with overall company philosophy, the claim liability estimate is determined which is expected to be adequate under reasonably likely circumstances. This estimate is developed using actuarial principles and assumptions that consider a number of items as appropriate, including but not limited to historical and current claim payment patterns, product variations, the timely implementation of appropriate rate increases and seasonality. The Company does not develop ranges in the setting of the claims liability reported in the financial statements

The Company's claim liabilities are estimated using the developmental method, which involves the use of completion factors for most incurral months, supplemented with additional estimation techniques, such as loss ratio estimates, in the most recent incurral months. This method applies completion factors to claim payments in order to estimate the ultimate amount of the claim. These completion factors are derived from historical experience and are dependent on the incurred dates of the claim payments. The completion factors are selected so that they are equally likely to be redundant as deficient.

For the majority of health insurance products offered through the Self-Employed Agency Division, the Company establishes the claims liability using the original incurred date. Under the original incurred date methodology, claims liabilities for the cost of all medical services related to the accident or sickness are recorded at the earliest date of diagnosis or treatment, even though the medical services associated with such accident or sickness might not be rendered to the insured until a later financial reporting period. A break in service of more than six months will result in the establishment of a new incurred date for subsequent services. A new incurred date will be established if claims payments continue for more than thirty-six months without a six month break in service.

In estimating the ultimate level of claims for the most recent incurral months, the Company uses what it believes are prudent estimates that reflect the uncertainty involved in these incurral months. An extensive degree of judgment is used in this estimation process. For healthcare costs payable, the claim liability balances and the related benefit expenses are highly sensitive to changes in the assumptions used in the claims liability calculations. With respect to health claims, the items that have the greatest impact on the Company's financial results are the medical cost trend, which is the rate of increase in healthcare costs, and the unpredictable variability in actual experience. Any adjustments to prior period claim liabilities are included in the benefit expense of the period in which adjustments are identified. Due to the considerable variability of healthcare costs and actual experience, adjustments to health claim liabilities usually occur each quarter and are sometimes significant.

The Company believes that its recorded claim liabilities are reasonable and adequate to satisfy its ultimate claims liability. Each of the Company's major operating units has an actuarial staff that has primary responsibility for assessing the claim liabilities. The Company's Corporate Risk Management staff has an oversight process in place to provide final review of the establishment of the claim liabilities. The Company uses its own experience as appropriate and relies on industry loss experience as necessary in areas where the Company's data is limited. Our estimate of claim liabilities represents management's best estimate of the Company's liability as of December 31, 2006.

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The completion factors and loss ratio estimates in the most recent incurred months are the most significant factors affecting the estimate of the claim liability. The Company believes that the greatest potential for variability from estimated results is likely to occur at its SEA Division. The following table illustrates the sensitivity of these factors and the estimated impact to the December 31, 2006 unpaid claim liability for the SEA Division. The scenarios selected are reasonable based on the Company's past experience, however future results may differ.

Increase (Decrease) in Factor	Completion Factor(a)		Loss Ratio Estimate(b)	
	Increase (Decrease) in Estimated Claim Liability (In thousands)	Increase (Decrease) in Estimated Claim Liability (In thousands)	Increase (Decrease) in Ratio	Increase (Decrease) in Estimated Claim Liability (In thousands)
0.015	\$	(28,638)	6	\$ 35,379
0.010		(19,756)	3	17,690
0.005		(10,054)	(3)	(17,690)
(0.005)		10,166	(6)	(35,379)
(0.010)		20,446	(9)	(53,069)
(0.015)		30,841	(12)	(70,758)

(a) Impact due to change in completion factors for incurred months prior to the most recent five months.

(b) Impact due to change in estimated loss ratio for the most recent five months.

The SEA Division also makes various refinements to the claim liabilities as appropriate. These refinements estimate liabilities for circumstances, such as an excess pending claims inventory (*i.e.*, inventories of pending claims in excess of historical levels) and disputed claims. For example, the Company closely monitors the level of claims that are pending. When the level of pending claims appears to be in excess of normal levels, the Company typically establishes a liability for excess pending claims. The Company believes that such an excess pending claims liability is appropriate under such circumstances because of the operation of the developmental method used by the Company to calculate the principal claim liability, which method develops or completes paid claims to estimate the claim liability. When the pending claims inventory is higher than would ordinarily be expected, the level of paid claims is correspondingly lower than would ordinarily be expected. This lower level of paid claims, in turn, results in the developmental method yielding a smaller claim liability than would have been yielded with a normal level of paid claims, resulting in the need for an augmented claim liability.

With respect to business at its Disposed Operations, the Company assigned incurred dates based on the date of service. This definition estimated the liability for all medical services received by the insured prior to the end of the applicable financial period. Appropriate adjustments were made in the completion factors to account for pending claim inventory changes and contractual continuation of coverage beyond the end of the financial period.

Set forth below is a summary of claim liabilities by business unit at each of December 31, 2006, 2005 and 2004:

	At December 31,		
	2006	2005	2004
	(In thousands)		

Self-Employed Agency Division	\$ 417,571	\$ 438,857	\$ 493,406
Life Insurance Division	11,472	10,989	12,072
Other Insurance	14,289	16,247	5,144
Disposed Operations(1)	1,218	79,908	100,157
Subtotal	444,550	546,001	610,779
Reinsurance recoverable(2)	72,582	12,105	11,808
Total claim liabilities	\$ 517,132	\$ 558,106	\$ 622,587

(1) Reflects claims liabilities associated with the Company's former Student Insurance Division and Star HRG Division. The claims liabilities remaining at December 31, 2006 represent the residual liability associated with a closed block short-term product previously offered by, and retained by the Company in the 2006 sale of, the Student Insurance Division.

(2) Reflects liability related to unpaid losses recoverable.

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Activity in the claims liability is summarized as follows:

	Year Ended December 31,		
	2006	2005	2004
	(In thousands)		
Claims liability at beginning of year	\$ 546,001	\$ 610,779	\$ 563,045
Less: Claims liability paid on business disposed	(68,617)		
Add:			
Incurred losses, net of reinsurance, occurring during:			
Current year	1,059,032	1,191,723	1,196,421
Prior years	(90,697)	(124,996)	(90,914)
Total incurred losses, net of reinsurance	968,335	1,066,727	1,105,507
Deduct:			
Payments for claims, net of reinsurance, occurring during:			
Current year	664,220	765,767	714,361
Prior years	336,949	365,738	343,412
Total paid claims, net of reinsurance	1,001,169	1,131,505	1,057,773
Claims liability at end of year, net of related reinsurance recoverable (2006 \$72,582; 2005 \$12,105; 2004 \$11,808)	\$ 444,550	\$ 546,001	\$ 610,779

Claims Liability Development Experience

The developmental method used by the Company to estimate most of its claim liabilities produces a single estimate of reserves for both in course of settlement (ICOS) and incurred but not reported (IBNR) claims on an integrated basis. Since the IBNR portion of the claim liability represents claims that have not been reported to the Company, this portion of the liability is inherently more imprecise and difficult to estimate than other liabilities. A separate IBNR or ICOS reserve is estimated from the combined reserve by allocating a portion of the combined reserve based on historical payment patterns. Approximately 83-85% of the Company's claim liabilities represent IBNR claims.

Set forth in the table below is the summary of the incurred but not reported claim liability by business unit at each of December 31, 2006, 2005 and 2004:

	At December 31,		
	2006	2005	2004
	(In thousands)		
Self Employed Agency Division	\$ 346,060	\$ 368,556	\$ 416,299
Student Insurance Division	1,182	59,957	79,766
Star HRG Division		15,852	15,286
Life Insurance Division	4,254	4,725	5,546

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Other Insurance	14,177	16,007	4,936
Subtotal	365,673	465,097	521,833
Reinsurance recoverable	65,341	7,971	8,589
Total IBNR claim liability	431,014	473,068	530,422
ICOS claim liability	78,877	80,904	88,946
Reinsurance recoverable	7,241	4,134	3,219
Total ICOS claim liability	86,118	85,038	92,165
Total claim liability	\$ 517,132	\$ 558,106	\$ 662,587
Percent of IBNR to Total	83%	85%	85%

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Over time, the developmental method replaces anticipated experience with actual experience, resulting in an ongoing re-estimation of the claims liability. Since the greatest degree of estimation is used for more recent periods, the most recent prior year is subject to the greatest change.

Set forth in the table below is a summary of the claims liability development experience (favorable) unfavorable by business unit in the Company's Insurance segment for each of the years ended December 31, 2006, 2005 and 2004:

	Year Ended December 31,		
	2006	2005	2004
	(In thousands)		
Self-Employed Agency Division	\$ (85,784)	\$ (121,362)	\$ (91,720)
Life Insurance Division	(510)	337	(926)
Other Insurance	(2,530)	805	1
Disposed Operations	(1,873)	(4,776)	1,731
Total favorable	\$ (90,697)	\$ (124,996)	\$ (90,914)

Impact on SEA Division. As indicated in the table above, incurred losses developed at the SEA Division in amounts less than originally anticipated due to better-than-expected experience on the health business in the SEA Division in each of 2006, 2005 and 2004. For the SEA Division, the (favorable) unfavorable claims liability development experience in the prior year's reserve for each of the years ended December 31, 2006, 2005 and 2004 is set forth in the table below by source:

	Year Ended December 31,		
	2006	2005	2004
	(In thousands)		
Development in the most recent incurral months	\$ (35,504)	\$ (72,728)	\$ (42,947)
Development in completion factors	(6,612)	(21,095)	(7,664)
Development in large claim reserve	(10,555)	(8,455)	(5,425)
Development in reserves for regulatory and legal matters	(4,762)	(6,971)	18,906
Change in estimate for ACE rider	(24,165)	(7,613)	
Other change in estimate as disclosed below			(47,794)
Other	(4,186)	(4,500)	(6,796)
Total (redundancy) inadequacy	\$ (85,784)	\$ (121,362)	\$ (91,720)

As indicated in the table above, considerable redundancies in each year are associated with the estimate of claim liabilities for the most recent incurral months. The Company has limited data with respect to these most recent incurral months and, accordingly, estimates are based primarily on anticipated experience, taking into account the impact of the Company's rate changes relative to expected medical trend. Since late 2003, the Company has severely reduced the level of rate increases on its underlying scheduled health insurance coverage in response to experience that has been more favorable than was assumed in the establishment of the premium rates. This favorable experience first appeared in incurred months in the latter half of 2002, which with hindsight proved to be much more favorable than prior

experience would have suggested. At the end of 2003 and again at the end of 2004, there appeared to be evidence that loss ratios on these products were increasing again toward the anticipated levels, though hindsight eventually showed that much of this deterioration was the result of the redundancy that had developed in the completion factors, which were adjusted in the third quarter of 2005. Accordingly, the estimated claim liabilities assumed experience had deteriorated as medical trend rates exceeded actual rate increases. In hindsight, actual results were unusually favorable in each case. In the third quarter of 2005, claim liability estimates were adjusted to reflect this unusually favorable experience. Additional adjustments were made in the third quarter of 2006 to reflect this continuing favorable experience.

The total favorable claims liability development experience for 2006 in the amount of \$85.8 million represented 19.5% of total claim liabilities established for the SEA Division at December 31, 2005. Most of

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the redundancy (\$35.5 million, excluding a refinement to the claim liability for the ACE rider described below) is attributable to experience in the most recent incurral months developing more favorably than anticipated. The Company also experienced a redundancy attributable to the completion factors utilized of \$6.6 million (excluding the refinements in the ACE completion factors in the third and fourth quarters of 2006 described below) as the result of claims developing in amounts less than anticipated by the completion factors used at December 31, 2005. Furthermore, the SEA Division also benefited from a reduction in the claim liability of \$10.8 million in its reserve for large claims as a result of a change in estimate recorded in the second quarter of 2006, of which \$10.6 million was attributable to prior years. In addition, the Company experienced favorable development of approximately \$4.8 million associated with its reserves for regulatory and legal matters due to settlements of certain litigation and matters on terms more favorable than originally anticipated. In 2006, the Company made certain refinements to its estimate of the claim liability for the ACE rider which contributed to the favorable claims liability development experience for the year, including revisions to the completion factors utilized in computing this reserve as well as revisions to the estimate of the unpaid claim liability for the most recent incurral months. The impact of these refinements on the development of the claim liabilities established at December 31, 2005 is \$24.2 million, including \$19.1 million attributable to the revised completion factors and \$5.1 million attributable to the estimate in the most recent incurral months. The remaining favorable experience in 2006 in the claims liability attributable to other issues was \$4.2 million, or 1.0% of total claim liabilities established for the SEA Division at December 31, 2005.

The total favorable claims liability development experience for 2005 in the amount of \$121.4 million represented 24.6% of total claim liabilities established for the SEA Division at December 31, 2004. The favorable claims liability development experience in 2005 reflected a benefit of \$33.3 million recorded in the third quarter of 2005 attributable to a refinement of the Company's estimate for its claim liability on its health insurance products, which adjustment resulted from a refinement of the estimate of the unpaid claim liability for the most recent incurral months (\$20.9 million, included in the table above as part of the development in the most recent incurral months) and an update of the completion factors used in the developmental method of estimating the unpaid claim liability to reflect more current claims administration practices (\$12.3 million, included in the table above as part of the development in the completion factors). The favorable claims liability development experience at the SEA Division in 2005 also reflected the effects of a favorable adjustment in the amount of \$7.6 million recorded in the first quarter of 2005 attributable to a refinement of an estimate for the Company's claim liability established with respect to the ACE (accumulated covered expense) rider that provides for catastrophic coverage on the SEA Division's scheduled health insurance products. Excluding the impact of the refinements discussed above, the remaining favorable experience in 2005 in the claims liability was \$80.5 million, or 16.3% of total claim liabilities established for the SEA Division at December 31, 2004. Most of the remaining redundancy (\$51.8 million in addition to the refinement described above) is attributable to experience in the five most recent incurral months developing more favorably than anticipated (as discussed above) and unanticipated improvements on certain closed blocks that appeared to have been deteriorating based on experience available at the end of 2004. The Company experienced an additional redundancy in the completion factors of \$8.8 million (in addition to the redundancy from the refinement previously described in the third quarter of 2005) as the result of claims developing in amounts less than anticipated by the completion factors used at December 31, 2004. The Company also experienced favorable development of \$8.5 million in its reserve for large claims as a result of lower frequency and severity of large claims than anticipated. In addition, the Company experienced favorable development of approximately \$7.0 million associated with its reserves for regulatory and legal matters due to settlements of certain matters on terms more favorable than originally anticipated.

The total favorable claims liability development experience for 2004 in the amount of \$91.7 million represented 20.2% of total claim liabilities established for the SEA Division at December 31, 2003. The favorable claims liability development experience at the SEA Division in 2004 reflected the effect of \$47.8 million in claim liabilities established during 2003 in response to a rapid pay down during 2003 of an excess pending claims inventory. In particular, during 2003 the Company observed a change in the distribution of paid claims by incurred date; more paid claims were assigned to recent incurred dates than had been the case on paid claims in prior years. Assignment of paid

claims with more recent incurred dates typically results in an understatement of the claim development liability, resulting in the need for augmented claim liabilities. The Company believes that the deviation from historical experience in incurred date assignment was a natural consequence of the effort required to reduce a claims backlog, which the Company was experiencing at the SEA Division during the course of 2003. However, as

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the actual claims experience developed in 2004, these augmented claim liabilities in the amount of \$47.8 million proved to be redundant. These claim liabilities were released during 2004 and, as a result, did not influence the level of claim liabilities redundancies in 2005 and will not influence the level of claim liabilities redundancies in future periods. Excluding the impact of the augmented claim liabilities established at December 31, 2003 in response to the rapid pay down during 2003 of an excess pending claims inventory, the favorable experience in 2004 in the claims liability was \$43.9 million, or 9.6% of total claim liabilities established for the SEA Division at December 31, 2003. Of the remaining redundancy, \$42.9 million was attributable to experience in the five most recent incurral months developing more favorably than anticipated as a result of unanticipated improvements in the experience on products that had been showing indications of deterioration in response to a reduction in the level of rate increases. The Company experienced an additional favorable development in the completion factors of \$7.7 million as a result of lower than expected claim payments. The Company also experienced favorable development of \$5.4 million in its reserve for large claims as a result of lower frequency and severity of large claims than anticipated. In addition, the Company experienced unfavorable development of nearly \$18.9 million associated with its reserves for regulatory and legal matters as the result of certain claim litigation and the establishment of additional reserves in response to claim payment issues raised in a market conduct examination.

Over time, the developmental method replaces anticipated experience with actual experience, resulting in an ongoing re-estimation of the claims liability. Since the greatest degree of estimation is used for more recent periods, the most recent prior year is subject to the greatest change. Recent actual experience has produced lower levels of claims payment experience than originally expected.

In response to the redundancies reflected in 2004 and 2005, the Company elected in the third quarter of 2005 for the SEA Division to modify the assumptions used in the most recent incurral months to rely less on loss ratios assumed in the establishment of premium rates and more on historical experience, reducing the claim liability estimate in the most recent incurral months by \$20.9 million. In addition, in response to observed changes in the pattern of claim payments, the Company elected in the third quarter of 2005 to update the completion factors used in the developmental method to estimate the claim liabilities at the SEA Division in a manner designed to produce new completion factors that were anticipated to be equally likely to be redundant as deficient. As a result of the new completion factors, the claims liability estimate was reduced by \$12.3 million. These two adjustments in 2005 resulted in an aggregate reduction in the claim liability estimate in the amount of \$33.3 million.

Impact on Life Insurance Division. The varied claim liability development experience at the Life Insurance Division for each of the years presented is due to the development of a closed block of workers' compensation business. The Life Insurance Division previously wrote workers' compensation insurance and similar group accident coverage for employers in a limited geographical market. In May 2001, the Company made the decision to terminate this operation, and all existing policies were terminated as the policies came up for renewal over the succeeding twelve months. The closing of new and renewal business starting in July of 2001 had the effect of concentrating the claims experience into existing policies and eliminating any benefits that might accrue from improved underwriting of new business or liabilities released on newer claims that might settle more quickly. The effect of closing a block of this type of business is difficult to estimate at the date of closing, due to the longer claims tail usually experienced with workers' compensation coverage, the tendency of claims to concentrate in severity but without an associated degree of predictability as the number of cases decreases, and the unpredictable costs of protracted litigation often associated with the adjudication of claims under workers' compensation policies.

Impact on Other Insurance. Through our 82.5%-owned subsidiary, ZON Re USA LLC (ZON Re), we underwrite, administer and issue accidental death, accidental death and dismemberment (AD&D), accident medical and accident disability insurance products, both on a primary and on a reinsurance basis. The favorable claim liability experience of \$2.5 million in 2006 is due to the release of reserves held at December 31, 2005 for catastrophic excess of loss contracts expiring during 2006. The unfavorable claim liability development experience at ZON Re in 2005 in the

amount of \$805,000 was due to certain large claims reported in 2005 associated with claims incurred in the prior year.

Impact on Disposed Operations. The products of the Student Insurance and Star HRG Divisions consisted principally of medical insurance. In general, medical insurance business, for which incurred dates are assigned

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based on date of service, has a short tail, which means that a favorable development or unfavorable development shown for prior years relates primarily to actual experience in the most recent prior year.

The favorable claim liability development experience at the Student Insurance Division in 2006 and 2005 was \$478,000 and \$5.2 million, respectively. This favorable development is due to claims in the current year developing more favorably than indicated by the loss trends used to determine the claim liability at December 31 of the preceding year. The unfavorable claims liability development experience in 2004 in the amount of \$4.7 million reflects the effects of a delay in processing of prior-year claims and higher-than-expected claim experience associated with the business written for the 2003-2004 school year.

The favorable claims liability development experience at Star HRG Division of \$1.4 million in 2006 includes the effects of claims in 2006 developing more favorably than indicated by the loss trends in 2005 used to determine the claim liability at December 31, 2005. The unfavorable claim liability development at the Star HRG Division in 2005 of \$410,000 is within the normal statistical variation in the model used to develop the reserve. The actual development of prior years' claims exceeded the expected development of the claims liability. The favorable claims liability development experience of \$3.0 million in 2004 includes the effects of claims in 2004 developing more favorably than indicated by the loss trends in 2003 used to determine the claim liability at December 31, 2003.

Accounting for Policy Acquisition Costs

Health Policy Acquisition Costs

The Company incurs various costs in connection with the origination and initial issuance of its health insurance policies, including underwriting and policy issuance costs, costs associated with lead generation activities and distribution costs (*i.e.*, sales commissions paid to agents). The Company defers those costs that vary with production. The Company generally defers commissions paid to agents and premium taxes with respect to the portion of health premium collected but not yet earned and the Company amortizes the deferred expense over the period as and when the premium is earned. Costs associated with generating sales leads with respect to the health business issued through the SEA Division are capitalized and amortized over a two-year period, which approximates the average life of a policy. For financial reporting purposes, other underwriting and policy issuance costs (which the Company estimates are more fixed than variable) with respect to health policies issued through the Company's SEA and Other Insurance division are expensed as incurred.

At December 31, 2006, the Company changed its accounting policy, effective January 1, 2006 with respect to the amortization of a portion of deferred acquisition costs associated with commissions paid to agents. Generally, the first year and second year commission rates on policies issued by the Company's SEA Division are higher than renewal year commission rates. Commencing in 2006, the Company changed its accounting methodology with respect to the first year and second year excess commissions and now amortizes those excess commissions over a two year period (based on recent persistency studies showing that SEA policies have an average life of 2.09 years) rather than expensing the excess commissions in the period the commissions were paid. *See* Management's Discussion and Analysis of Financial Condition and Results of Operations *2006 Change in Accounting Policy*.

Life Policy Acquisition Costs

The Company incurs various costs in connection with the origination and initial issuance of its life insurance policies, including underwriting and policy issuance costs. The Company defers those costs that vary with production. The Company capitalizes commission and issue costs primarily associated with the new business of its Life Insurance Division. Deferred acquisition costs consist primarily of sales commissions and other underwriting costs of new life insurance sales. Policy acquisition costs associated with traditional life business are capitalized and amortized over the

estimated premium-paying period of the related policies, in proportion to the ratio of the annual premium revenue to the total premium revenue anticipated. Such anticipated premium revenue, which is modified to reflect actual lapse experience, is estimated using the same assumptions as are used for computing policy benefits. For universal life-type and annuity contracts, capitalized costs are amortized at a constant rate based on the present value of the estimated gross profits expected to be realized on the book of contracts.

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Other

The cost of business acquired through acquisition of subsidiaries or blocks of business is determined based upon estimates of the future profits inherent in the business acquired. Such costs are capitalized and amortized over the estimated premium-paying period. Anticipated investment income is considered in determining whether a premium deficiency exists. The amortization period is adjusted when estimates of current or future gross profits to be realized from a group of products are revised.

The Company monitors and assesses the recoverability of deferred health and life policy acquisition costs on a quarterly basis.

Goodwill and Other Identifiable Intangible Assets

The Company accounts for goodwill and other intangible assets under Financial Accounting Standards Board Statement 142, *Goodwill and Other Intangible Assets*. Statement 142 requires that goodwill and other intangible assets with indefinite useful lives no longer be amortized, but instead be tested for impairment at least annually. Statement 142 also requires that intangible assets with estimable useful lives be amortized over their respective estimated useful lives to their estimated residual values and reviewed for impairment. The Company has determined that it will review goodwill and other intangible assets for impairment as of November 1 of each year or more frequently if certain indicators arise. An impairment loss would be recorded in the period such determination was made. Following the Company's annual review in 2006 for impairment of the goodwill and other intangible assets related to continuing operations, the Company recorded an impairment charge in the amount of \$496,000 related to the HealthMarket customer list acquired in October 2004. *See* Note F of Notes to Consolidated Financial Statements.

Accounting for Agent Stock Accumulation Plans

The Company sponsors a series of stock accumulation plans (the Agent Plans) established for the benefit of the independent insurance agents and independent sales representatives associated with UGA Association Field Services, New United Agency and Cornerstone America. The Company has established a liability for future unvested benefits under the Agent Plans and adjusts the liability based on the fair value of the Company's Common Stock. The accounting treatment of the Company's Agent Plans has resulted and will continue to result in unpredictable stock-based compensation charges, dependent upon fluctuations in the fair value of HealthMarkets Class A-2 common stock. These unpredictable fluctuations in stock based compensation charges may result in material non-cash fluctuations in the Company's results of operations. *See* discussion above under the caption Variable Stock-Based Compensation and Note Q of Notes to Consolidated Financial Statements.

Investments

The Company has classified its investments in securities with fixed maturities as available for sale. Investments in equity securities and securities with fixed maturities have been recorded at fair value, and unrealized investment gains and losses are reflected in stockholders' equity. Investment income is recorded when earned, and capital gains and losses are recognized when investments are sold. Investments are reviewed quarterly to determine if they have suffered an impairment of value that is considered other than temporary. If investments are determined to be impaired, a loss is recognized at the date of determination.

Testing for impairment of investments also requires significant management judgment. The identification of potentially impaired investments, the determination of their fair value and the assessment of whether any decline in value is other than temporary are the key judgment elements. The discovery of new information and the passage of

time can significantly change these judgments. Revisions of impairment judgments are made when new information becomes known, and any resulting impairments are made at that time. The economic environment and volatility of securities markets increase the difficulty of determining fair value and assessing investment impairment. The same influences tend to increase the risk of potentially impaired assets.

Investments are reviewed quarterly (or more frequently if certain indicators arise) to determine if they have suffered an impairment of value that is considered other than temporary. Management's review considers the following indicators of impairment: fair value significantly below cost; decline in fair value attributable to specific

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adverse conditions affecting a particular investment; decline in fair value attributable to specific conditions, such as conditions in an industry or in a geographic area; decline in fair value for an extended period of time; downgrades by rating agencies from investment grade to non-investment grade; financial condition of the issuer deterioration and situations where dividends have been reduced or eliminated or scheduled interest payments have not been made. Management monitors investments where two or more of the above indicators exist. The Company also identifies investments in economically challenged industries. If investments are determined to be impaired, a loss is recognized at the date of determination.

The Company seeks to match the cash flows of invested assets with the payment of expected liabilities. By doing this, the Company attempts to make cash available as payments become due. If a significant mismatch of the maturities of assets and liabilities were to occur, the impact on the Company's results of operations could be significant.

Non-Consolidated Subsidiary

On August 3, 2006, Grapevine Finance LLC (Grapevine) was incorporated in the State of Delaware as a wholly owned subsidiary of HealthMarkets, LLC. On August 16, 2006, the Company distributed and assigned to Grapevine the \$150.8 million promissory note (CIGNA Note) and related Guaranty Agreement issued by Connecticut General Corporation in the Star HRG sale transaction (see Note C of Notes to Consolidated Financial Statements). On August 16, 2006, Grapevine issued \$72.4 million of its senior secured notes to an institutional purchaser collateralized by Grapevine's assets including the CIGNA Note. The net proceeds from the senior secured notes were distributed to HealthMarkets, LLC

Grapevine is a non-consolidated qualifying special purpose entity as defined in FASB 140, *Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*. As a qualifying special purpose entity, HealthMarkets does not consolidate the financial results of Grapevine and accounts for its residual interest in Grapevine as an investment in fixed maturity securities pursuant to EITF 99-20, *Recognition of Interest Income and Impairment on Purchase and Retained Beneficial Interests in Securitized Financial Assets*.

The Company measures the fair value of its residual interest in Grapevine using a present value model incorporating the following two key economic assumptions: (1) the timing of the collections of interest on the CIGNA Note, payments of interest expense on the senior secured notes and payment of other administrative expenses and (2) an assumed discount rate equal to the 15 year swap rate.

Deferred Taxes