HealthMarkets, Inc.
Form 10-K
March 08, 2012
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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, 2011

Or

¨ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from to

Commission file no. 001-14953

HealthMarkets, Inc.

(Exact name of registrant as specified in its charter)

Delaware	75-2044750
(State or other jurisdiction of Incorporation or organization)	(IRS Employer Identification No.)

9151 Boulevard 26, North Richland Hills, Texas 76180

(Address of principal executive offices, zip code)

(817) 255-5200

(Registrant s phone number, including area code)

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 þ

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 þ

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 þ No ¨

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes þ 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 þ

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

Large accelerated filer ¨	Accelerated filer ¨
Non-accelerated filer þ (Do not check if a smaller reporting company)	Smaller reporting company ¨

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

Effective April 5, 2006, all of the registrant s Class A-1 common stock 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. As of June 30, 2011, 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 February 29, 2012, there were 27,851,302 outstanding shares of Class A-1 common stock and 2,775,036 outstanding shares of Class A-2 common stock.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the annual information statement for the 2012 annual meeting of stockholders are incorporated by reference into Part III.

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HEALTHMARKETS, INC.

and Subsidiaries

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Cautionary Statements Regarding Forward-Looking Statements

When we use the terms HealthMarkets , we , us , our , and the Company , we mean HealthMarkets, Inc. and its subsidiaries. This report and oth documents or oral presentations prepared or delivered by and on behalf of the Company contain or may contain forward-looking statements within the meaning of the safe harbor provisions of the United States Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements based upon management s expectations at the time such statements are made. The Company undertakes no obligation to publicly update or revise any forward-looking statements, whether as a result of new information, future events or otherwise. Forward-looking statements are subject to risks and uncertainties that could cause the Company s actual results to differ materially from those contemplated in the statements. Readers are cautioned not to place undue reliance on the forward-looking statements. All statements, other than statements of historical information provided or incorporated by reference herein, may be deemed to be forward-looking statements. Without limiting the foregoing, when used in written documents or oral presentations, the terms *anticipate, believe, estimate, expect, may, objective, plan, possible, potential, project, will* and similar expressions are intended to identify forward-looking statements. In addition to the assumptions and other factors referred to specifically in connection with such statements, factors that could impact the Company s business and financial prospects include, but are not limited to, those discussed under the caption *Item 1 Business, Item 1A. Risk Factors* and *Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations* and those discussed from time to time in the Company s various filings with the Securities and Exchange Commission or in other publicly disseminated written documents.

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PART I

Item 1. ***Business***

Introduction

HealthMarkets, Inc., a Delaware corporation incorporated in 1984, is a holding company, the principal asset of which is its investment in its wholly owned subsidiary, HealthMarkets, LLC. HealthMarkets, LLC s principal assets are its investments in its separate operating subsidiaries, including its regulated insurance subsidiaries. HealthMarkets conducts its insurance underwriting businesses through its indirect wholly owned insurance company subsidiaries, The MEGA Life and Health Insurance Company (MEGA), Mid-West National Life Insurance Company of Tennessee (Mid-West), The Chesapeake Life Insurance Company (Chesapeake) and HealthMarkets Insurance Company (HMIC), and conducts its insurance distribution business through its indirect insurance agency subsidiary, Insphere Insurance Solutions, Inc. (Insphere)

Through our insurance subsidiaries, we underwrite and administer a broad range of health and supplemental insurance products for individuals, families, the self-employed and small businesses. MEGA is an insurance company domiciled in Oklahoma and is licensed to issue health, life and annuity insurance policies in the District of Columbia and 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, the District of Columbia, 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 the District of Columbia and all states except New Jersey, New York and Vermont. HMIC is an insurance company domiciled in Oklahoma and is licensed to issue health and life insurance policies in the District of Columbia and all states except New York and New Hampshire.

In 2009, the Company launched its Insphere insurance agency. Insphere serves as an authorized insurance agency in 50 states and the District of Columbia, specializing in the distribution to the small business and middle-income markets. Insphere distributes life, health, long-term care and retirement insurance to these groups through a portfolio of products from nationally recognized insurance carriers. As of December 31, 2011, Insphere had offices in 36 states with over 2,900 independent agents, of which approximately 1,800 agents on average write health insurance applications each month. Insphere distributes products underwritten by the Company s insurance subsidiaries, as well as non-affiliated insurance companies.

Prior to 2010, the Company maintained a dedicated agency sales force that distributed products underwritten exclusively by the Company s own insurance subsidiaries. The development of Insphere as an independent career-agent distribution company, and the sale by Insphere agents of third party products, represents a significant shift in the Company s corporate strategy. We are now generally focused on business opportunities that allow us to maximize the value of the Insphere independent agent sales force, with particular focus on the sale of supplemental insurance products underwritten by the Company s insurance subsidiaries and third-party health insurance products underwritten by non-affiliated insurance companies. In 2010, we discontinued the sale of the Company s traditional scheduled benefit health insurance products and discontinued marketing all health benefit plans underwritten by our insurance subsidiaries in all but a limited number of states in which Insphere does not have access to third-party health insurance products. We believe that this shift better positions the Company for the future, particularly in light of changes resulting from the enactment, in March 2010, of the Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010 (collectively, the Health Care Reform Legislation). The Company continues to maintain a significant in-force block of health benefits plans and evaluates on an ongoing basis the impact of Health Care Reform Legislation on this block of business.

The Company operates four business segments: Commercial Health, Insphere, Corporate, and Disposed Operations. Through our Commercial Health Division, we underwrite and administer a broad range of health and supplemental insurance products. Insphere includes net commission revenue, agent incentives, marketing costs

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and costs associated with the continuing development of Insphere. Corporate includes investment income not allocated to the other segments, realized gains or losses, interest expense on corporate debt, the Company s student loan business, general expenses relating to corporate operations and operations that do not constitute reportable operating segments. Disposed Operations includes the remaining run out of the former Medicare Division and the former Other Insurance Division as well as the residual operations from the disposition of other businesses prior to 2009. (See Note 19 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.

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 Credit Suisse-DLJ Merchant Banking Partners (the Private Equity Investors). As of December 31, 2011, approximately 86.9% of our common equity securities were held by the Private Equity Investors, with the balance of our common equity securities held by current and former members of management and also by independent insurance agents through the HealthMarkets, Inc. InVest Stock Ownership Plan. As such, we remain subject to the periodic reporting and other requirements of the Securities Exchange Act of 1934, as amended. Our periodic filings with the United States Securities and Exchange Commission (the SEC), 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.healthmarketsinc.com free of charge as soon as reasonably practicable after such material is electronically filed with, or furnished to, the SEC.

Ratings

The Company s principal insurance subsidiaries historically have been assigned financial strength ratings from A.M. Best Company (A.M. Best). A.M. Best also assigned an issuer credit rating to HealthMarkets, Inc. In the second quarter of 2011, A.M. Best affirmed the financial strength ratings of MEGA, Mid-West and Chesapeake, and the issuer credit rating of HealthMarkets, as set forth below:

Mega	Financial Strength Rating	B++ (Good)
Mid-West	Financial Strength Rating	B++ (Good)
Chesapeake	Financial Strength Rating	B++ (Good)
HealthMarkets, Inc.	Issuer Credit Rating	bb (Speculative)

The A.M. Best ratings above 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 financial strength ratings currently range from A++ (Superior) to F (In Liquidation). A.M. Best s ratings are ba upon factors relevant to policyholders, agents, insurance brokers and intermediaries and are not directed to the protection of investors. 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 rs (Regulatory Supervision/Liquidation).

Commercial Health Division

Through our Commercial Health Division, we underwrite and administer a broad range of health and supplemental insurance products. These products are issued by our subsidiaries, MEGA, Mid-West and Chesapeake and, beginning in January 2010, are primarily distributed by the Insphere independent agent sales

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force. The Commercial Health Division generated revenues of $585.3 million, $798.7 million and $1.1 billion, representing 88%, 93% and 98% of our total revenue from continuing operations in 2011, 2010 and 2009, respectively. We currently have approximately 171,000 members insured or reinsured by the Company.

Health Insurance Products

The health insurance products underwritten by our insurance company subsidiaries are designed to accommodate individual needs and include traditional fee-for-service indemnity (choice of doctor) plans and plans with preferred provider organization (PPO) features, in which benefits are structured to encourage the use of providers with which we have negotiated lower fees for the services to be provided. Many of these plans are of a scheduled benefit nature and, as such, provide benefits equal to the lesser of the actual cost incurred for covered expenses or the maximum benefit stated in the policy.

These products feature 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. Historically, our scheduled/basic plans were offered with an optional benefit, the Accumulated Covered Expense (ACE) rider, that provides for catastrophic coverage 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.

In the second quarter of 2010, the Company determined that it would discontinue the sale of the Company s scheduled benefit health insurance products and significantly reduce the number of states in which the Company would market its health benefit plans in the future. After September 23, 2010, the effective date for many aspects of the Health Care Reform Legislation, the Company discontinued marketing all of its health benefit plans, in all but a limited number of states in which Insphere does not currently have access to third-party health insurance products. These actions reflect a number of factors, including (1) the Company s evaluation of National Health Care Reform Legislation which, among other things, requires a minimum medical loss ratio of 80% for the individual and small group markets beginning in 2011 and eliminates most annual caps on benefits - an important feature of our scheduled benefit products; (2) the Company s decision to focus on business opportunities that allow us to maximize the value of the Insphere independent agent sales force, with particular focus on the sale of third-party health insurance products underwritten by non-affiliated insurance companies and supplemental insurance products underwritten by the Company s insurance subsidiaries (which are generally not subject to the requirements of the Health Care Reform Legislation); and (3) the fact that in the states where third party health insurance plans distributed by Insphere have been introduced, they have, to a great extent, replaced the sale of the Company s own health benefit plan offerings.

The Company continues to maintain a significant in-force block of health benefit plans, and continues to underwrite and distribute its own health benefit plans in a limited number of states. The Company believes it has made all adjustments to this business to the extent required to date by the Health Care Reform Legislation. We expect that maintenance of the Company s in-force block of health benefit plans, at current levels, will present significant challenges resulting from, among other things, competitive pressure due to the shift in our distribution focus toward third-party product sales, and changes resulting from Health Care Reform Legislation. For non-grandfathered plans, these changes include, but are not limited to, the obligation to add mandated essential benefits , which is expected to significantly increase costs; limitations on the ability to vary premium based on assessment of underlying risk (including elimination of pre-existing condition exclusions and health status rating adjustments); and the creation of health insurance exchanges with standardized plans and potential guarantee issue of coverage for the individual and small group markets, which plans may be an attractive option for our existing customers and cause them to cancel their coverage with us. The Company evaluates, on an ongoing basis, the impact of the Health Care Reform Legislation on its in-force block of health benefit plans.

We expect the size of our in-force block of health benefit plans to continue decreasing over time and, as a result, we anticipate continuing declines in premium revenue and underwriting profits associated with our

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in-force block. We do not expect these earnings to be replaced fully by premium revenue and underwriting profits associated with our supplemental insurance product offerings, or by commission revenue generated from Insphere distribution, which will make it difficult to support administrative expenses at current levels. To better align expenses in light of dropping enrollment levels, the Company has been pursuing initiatives to significantly reduce administrative expenses, including but not limited to reductions in its workforce, consolidation of certain administrative functions and the reorganization of Insphere s field structure to make it more efficient, and we expect initiatives of this nature to continue in the future.

Supplemental Products

We have also developed and offer supplemental product lines designed to further protect against risks to which our customer is typically exposed. These products are sold to purchasers of the Company s health benefit plans, as well as to purchasers of third party products underwritten by non-affiliated insurance carriers that are distributed by Insphere. They are also sold on a stand-alone basis. These products are primarily underwritten by Chesapeake. In late 2010, Chesapeake introduced an extensive supplemental product portfolio currently available in 46 states. Chesapeake s supplemental products are marketed primarily under the SureBridge Insurance brand and distributed by Insphere agents as well as other independent, third party producers. Our supplemental product offerings include the following:

Dental and vision products: We offer multiple dental and vision products leveraging provider networks to provide varying combinations of coverage or discounts for periodic exams, corrective treatment and, in the case of vision, low co-payments on various lens types and discounts on vision products and services.

Disability: Our disability products provide income protection against short term disability (up to 24 months) resulting from an accident or illness, with benefits ranging from $1,000 to $2,500 per month.

Critical illness products: Our critical illness products provide a lump sum benefit (ranging from $5,000 to $60,000) for the first diagnosis of a specified disease/condition (including, but not limited to, cancer, heart attack, stroke and end stage renal disease) or major organ transplant. We also offer a separate cancer policy providing a lump sum benefit (ranging from $10,000 to $60,000) for the first diagnosis of internal cancer.

Accident products: Our portfolio includes three products, all of which provide payment directly to the insured. The product structures vary, ranging from products offering smaller benefit payments for a variety of conditions sustained or services received, to those targeting catastrophic accidents (resulting in conditions such as paraplegia or blindness) with lump sum benefits up to $60,000.

Hospital indemnity products: Our hospital indemnity products provide a daily benefit (ranging from $250 to $1,000 per day) for medically necessary inpatient confinements.

Bundled/Multi-Benefit Products: We have also developed supplemental insurance packages that combine benefits from several supplemental products, including packages providing an array of benefits, across a number of services and conditions, to meet the most common range of consumer needs.

We believe that Chesapeake offers one of the largest portfolios of individual supplemental products in the market. In the future, we expect to place an increasing emphasis on our supplemental product offerings, which are generally not subject to national health care reform legislation.

Association Products

Historically, a substantial portion of the products offered by our insurance subsidiaries were issued to members of independent membership associations that act as the master policyholder for such products,

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including the Alliance for Affordable Services (AAS) and Americans for Financial Security (AFS). The associations provide their members with access to a number of benefits and products, including health insurance underwritten by the HealthMarkets insurance subsidiaries. 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. Currently, in the limited number of states where the Company s insurance subsidiaries continue to offer their health benefit plans, these plans are offered to the individual market directly and not through associations. Association memberships continue to be offered, on both a stand-alone basis and sold together with health benefit plans, through Insphere (See Insphere Insurance Solutions, Inc. discussion below).

Marketing and Sales

In 2009, the Company launched Insphere in connection with the reorganization of its sales force into an independent career-agent distribution company. Beginning in 2010, primarily all of the health insurance products issued by our insurance subsidiaries are sold through independent agents contracted with Insphere who are compensated based upon level of sales production. Each of the Company s insurance subsidiaries maintains a distribution agreement with Insphere for the sale of its insurance products. Insphere also distributes products underwritten by non-affiliated insurance companies through its contracted agents.

We believe that providing agents with qualified leads enables them to achieve a higher close rate than with unqualified prospects. In connection with the launch of Insphere and reorganization of the Company s sales force, on December 31, 2009, the Company dissolved its former HealthMarkets Lead Marketing Group Inc. (LMG) subsidiary. LMG previously served as the Company s direct marketing group and generated membership and insurance prospect leads for use by the Company s contracted agents. Insphere now obtains leads for its contracted agents from third party sources.

Policy Design and Claims Management

The scheduled benefit health insurance products underwritten by the Company s insurance subsidiaries and offered through the second quarter of 2010 are principally designed to limit coverage 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.

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 the insurance products underwritten by the Company s insurance subsidiaries.

We maintain an administrative center with underwriting, claims management and administrative capabilities. Beginning in 2009, the Company began to outsource many of these functions, including new business processing, provider service calls and a larger portion of the claims processing functions, to third parties, including parties who may perform these functions offshore. The Company retains ultimate responsibility for ensuring that these functions are performed in a timely and appropriate manner. With respect to the administrative capabilities that the Company has retained, we continue to evaluate opportunities to subcontract additional services of this nature on an ongoing basis. If the Company determines that these functions can be performed effectively and more efficiently by third parties, it may choose to subcontract these functions.

Provider Network Arrangements and Cost Management Measures

The Company s insurance subsidiaries utilize a number of cost management programs to help them and their customers control medical costs. These measures include maintaining contracts with selected PPO provider networks through which our customers may obtain discounts on hospital and physician services that would

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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 an important factor in controlling medical claims costs, since there is often a significant difference between a network-negotiated rate and the non-discounted rate.

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; use of pre- and post-payment fee negotiation services; the use of code editing programs that evaluate claims prior to adjudication for inappropriate billing; and the use of third-party fraud detection and prevention programs. In addition, to control prescription drug costs, the Company maintains a contract with a pharmacy benefits management company that has participating pharmacies nationwide. We also utilize copayments, coinsurance, deductibles and annual limits to manage prescription drug costs.

Insphere Insurance Solutions, Inc.

In 2009, the Company formed Insphere, a Delaware corporation and a wholly owned subsidiary of HealthMarkets, LLC. Insphere serves as an authorized insurance agency in 50 states and the District of Columbia, specializing in the distribution to the small business and middle-income markets. Insphere distributes life, health, long-term care and retirement insurance to these groups through a portfolio of products from nationally recognized insurance carriers. Insphere operates through independent insurance agents and is managed by licensed insurance agents employed by Insphere. Many of Insphere s independent agents were previously associated with the Company s UGA-Association Field Services (formerly the principal marketing division of MEGA) and Cornerstone America (formerly the principal marketing division of Mid-West). Effective January 1, 2010, the field leadership hierarchy of the Insphere sales force was reorganized into separate geographical regions, each led by a Regional Vice President, with several Agency Managers under each Regional Vice President. Regional Vice Presidents and Agency Managers are full-time, salaried employees of Insphere, responsible for agent recruiting, training, and oversight activities. Sales Leaders and writing agents, who operate under Agency Managers, remain independent contractors, responsible for sales production. The Insphere agency structure was further streamlined in 2011. As of December 31, 2011, Insphere had offices in 36 states with over 2,900 independent agents, of which approximately 1,800 agents on average write health insurance applications each month. We believe that Insphere is one of the largest independent, career agent insurance distribution groups in the country and we are actively seeking to expand the size of the agency in 2012. The Company evaluates on an ongoing basis opportunities to enhance Insphere s growth potential.

The process of recruiting agents is extremely competitive. We believe that the primary factors in successfully recruiting and retaining effective agents are Insphere s commission levels and practices regarding advances on commissions, the availability of the HealthMarkets, Inc. InVest Stock Ownership Plan, the quality and diversity of the products available in Insphere s portfolio, training opportunities, agent incentives and support. Agents participate in a training program tailored by product. Classroom and field training, with respect to product content, is required and made available to the agents under the direction of Insphere. The support available to agents includes an integrated technology platform designed to support end-to-end agent functions (including business leads, point-of-sale tools and business quoting and enrollment) and optimize the agent experience with Insphere. We believe that the technology platform made available to agents differentiates Insphere from other sales agencies and helps Insphere attract and retain agents.

Insphere maintains marketing agreements for the distribution of health benefits plans with a number of non-affiliated insurance carriers as well as the Company s own insurance subsidiaries. The non-affiliated carriers include, among others, United Healthcare s Golden Rule Insurance Company (Golden Rule), Humana and Aetna, for which Insphere distributes individual health insurance products. The products offered by these third-party carriers and the Company s insurance subsidiaries offer coverage and benefit variations that may fit one consumer better than another. In the markets where Insphere has commenced distribution of these third-party

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carrier products, these products have, to a great extent, replaced the sale of the Company s own health benefit plans. In 2011, Insphere s sale of health benefit plans underwritten by these third-party carriers, in the aggregate, significantly exceeded the sale of the Company s own health benefit plans. In the fourth quarter of 2010, Insphere began distributing Medicare products, initially with Humana for the sale of Medicare Advantage, Medicare Advantage with Prescription Drug Coverage, Prescription Drug and Medicare Supplement plans. In the second quarter of 2011, Insphere entered into a marketing agreement with United Healthcare to distribute Medicare Advantage, stand-alone Prescription Drug and Medicare Supplement plans. Insphere also distributes supplemental insurance, life and annuity, long-term care and retirement insurance products for a variety of non-affiliated insurance carriers as well as the Company s own insurance subsidiaries. These products are sold both on a stand-alone basis and to purchasers of health benefit plans underwritten by non-affiliated insurance companies or the Company s insurance subsidiaries. Insphere continues to evaluate new distribution opportunities on an ongoing basis and intends to continue expanding its portfolio and the size of its field force by developing additional marketing arrangements. Insphere s marketing agreements are generally non-exclusive and terminable on short notice by either party for any reason.

Insphere generates revenue primarily from base commissions and override commissions received from insurance carriers whose policies are placed or written through Insphere s independent agents. The commissions are typically based on a percentage of the premiums paid by insureds to the carrier. In some instances, Insphere also receives bonus payments for achieving certain sales volume and other thresholds. Insphere typically receives commission payments on a monthly basis for as long as a policy remains active. As a result, much of our revenue for a given financial reporting period relates to policies sold prior to the beginning of the period and is recurring in nature. Commission rates are dependent on a number of factors, including the type of insurance, policy duration and the particular insurance company underwriting the policy. As a result of certain changes arising from Health Care Reform Legislation, including the 80% minimum medical loss ratio requirement, many of the carriers with which Insphere does business, including the Company s insurance subsidiaries, have reduced commission and override percentages. In the fourth quarter of 2010, Insphere received notice from a number of its health carriers that compensation levels in 2011 would be significantly lower than 2010 levels. The impact of these adjustments has been significant. (See Regulatory and Legislative Matters discussion below).

In 2010, Insphere entered into agreements with independent membership associations Alliance for Affordable Services (AAS) and Americans for Financial Security (AFS) pursuant to which Insphere s agents act as field service representatives for the associations. These agreements provide Insphere with the exclusive right to distribute association products for AAS and AFS. In this capacity, Insphere s agents enroll new association members and provide membership retention services. Insphere receives compensation from the associations, including fees associated with enrollment, member retention services, and membership marketing. Members of the associations pay a monthly fee for membership, in exchange for which they receive savings on a variety of benefits and services, including business benefits (e.g. tax, printing, and legal services), consumer benefits (e.g. rental car, travelers auto insurance, apparel, hotel and amusement park discounts) and health benefits. Insphere evaluates on an ongoing basis association product opportunities.

Disposed Operations

We exited the Medicare Advantage market as an underwriter and sold ZON-Re USA, LLC (ZON-Re) because they were not part of the fundamental long term focus of the Company. We are now generally focused on business opportunities that allow us to maximize the value of the Insphere independent agent sales force.

The Other Insurance Division consisted of ZON-Re, an 82.5%-owned subsidiary, which underwrote, administered and issued 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 Company distributed these products through professional reinsurance intermediaries and a network of independent commercial insurance agents, brokers and third party administrators. On June 5, 2009, HealthMarkets, LLC, entered into an Acquisition Agreement for the sale of its 82.5% membership

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interest in ZON-Re to Venue Re, LLC which closed effective June 30, 2009. The Company continues to reflect the existing insurance business in its financial statements to final termination of substantially all liabilities.

In 2007, we initiated efforts to expand into the Medicare market as an underwriter. In the fourth quarter of 2007, we began offering a new portfolio of Medicare Advantage Private-Fee-for-Service Plans in selected markets in 29 states with calendar year coverage effective for January 1, 2008. Policies were issued by our Chesapeake subsidiary, under a contract with the Centers for Medicare and Medicaid Services. In July 2008, the Company determined it would not continue to participate in the Medicare business after the 2008 plan year.

Ceded Reinsurance

The Company s insurance subsidiaries reinsure portions of the coverage provided by their insurance products with other insurance companies on both an excess-of-loss and coinsurance basis. Reinsurance agreements are intended to limit an insurer s maximum loss. Historically, we used reinsurance for our health insurance business for limited purposes only. However, the implementation of Health Care Reform Legislation resulted in a number of changes to the Company s in force block of business, including elimination of a number of policy benefit limits. In an effort to mitigate the risk of loss associated with large medical claims, effective April 1, 2011, the Company s principal insurance subsidiaries entered into an excess of loss reinsurance agreement with Zurich American Insurance Company. Under the reinsurance agreement, the Company retains liability in the amount of $1 million per member, per year and the reinsurer is responsible for amounts in excess of $1 million per member, per year. The reinsurance agreement is limited to membership in effect on or after the contract date and covers incurred claims through the end of 2012. With respect to life insurance policies, the maximum retention by MEGA, Mid-West and Chesapeake on one individual is generally $200,000. In connection with the sale of our former Life Insurance Division business, substantially all of the insurance policies associated with the Life Insurance Division were reinsured by Wilton Reassurance Company or its affiliates on a 100% coinsurance basis, effective July 1, 2008. The Company s insurance subsidiaries evaluate on an ongoing basis opportunities arising from reinsurance arrangements.

Competition

We compete with other companies in each of our lines of business. With respect to the business of our Commercial Health 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. Competition is based on a number of factors, including quality of service, product features, price, scope of distribution, scale, financial strength ratings and name recognition. Some of our competitors may offer a broader array of products than our insurance subsidiaries, have a greater diversity of distribution resources, have better brand recognition, have more competitive pricing, have lower cost structures or, with respect to insurers, 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 entered the market for individual health and supplemental insurance products.

With respect to Insphere, we compete for business, as well as for agents and distribution relationships, with other distributors. The business in which Insphere engages is highly competitive and there are many insurance agencies, brokers and intermediaries who actively compete with Insphere. We also compete with insurance companies that sell their products directly to customers, and do not use or pay commissions to third-party agents or brokers. In addition, the Internet continues to be a source for direct placement of business and creates additional competition for Insphere. Government benefits relating to health, disability and retirement are alternatives to private insurance and may indirectly compete with our businesses. Insphere believes that it can

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remain competitive due to several factors, including its size, the level of training and support provided to its agents, including technology-based support, compensation levels and the availability of the HealthMarkets, Inc. InVest Stock Ownership Plan. However, if Insphere is unable to appropriately address competitive challenges, its business could be adversely affected.

Regulatory and Legislative Matters

National Health Care Reform Legislation

In March 2010, Health Care Reform Legislation was signed into law, which will result in broad-based material changes to the United States health care system. The Health Care Reform Legislation has, and is expected to continue to, significantly impact our business, including but not limited to the minimum medical loss ratio requirements applicable to our insurance subsidiaries as well to health insurance carriers doing business with Insphere. While not all-inclusive, the following material provisions of the Health Care Reform Legislation are subject to ongoing evaluation by the Company:

- establishment of a minimum medical loss ratio of 80% for the individual and small group markets beginning in 2011, with rebates to customers required for medical loss ratio amounts under the minimum;
- expansion of dependent coverage to include adult children up to age 26;
- elimination of most annual and all lifetime caps on benefits;
- elimination of pre-existing condition exclusions for certain dependents;
- requirements that limit the ability of health insurance providers to vary premium based on assessment of underlying risk;
- payment of first dollar preventive care benefits for non-grandfathered business;
- establishment of specific benefit design requirements, rating and pricing limits and guaranteed issue requirements;
- obligation to add coverage for mandated essential benefits for non-grandfathered plans (currently expected to be effective in 2014);
- creation of health insurance exchanges (currently expected to be effective in 2014) with standardized plans and potential guarantee issue of coverage requirements for the individual and small group markets, which plans may be an attractive option for our existing customers and cause them to cancel their coverage with us;
- prohibitions on most policy rescissions;
- significant annual taxes and/or assessments on health insurance providers which may not be deductible for income tax purposes; and

limitations on the deductibility of executive compensation under Section 162(m) of the Internal Revenue Code for health insurance providers.

Provisions of the Health Care Reform Legislation become effective at various dates over the next several years and a number of additional steps are required to implement these requirements, including, without limitation, further guidance and clarification in the form of final implementing regulations for certain key aspects of the legislation. Due to the complexity of the Health Care Reform Legislation, gradual implementation and pending status of certain guidance and regulations, the full impact of Health Care Reform Legislation on our business is not yet fully known. However, we have dedicated material resources and, in the future, expect to dedicate additional material resources and to incur material expenses (including but not limited to additional claims expenses) as a result of Health Care Reform Legislation.

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In addition, the Health Care Reform Legislation has been the subject of litigation in a number of federal district courts challenging the constitutionality of all or certain aspects of the legislation including, among other things, the individual mandate element of the legislation which requires individuals to purchase health insurance coverage or become subject to penalties. The United States Supreme Court is expected to review certain aspects of the Health Care Reform Legislation, including the constitutionality of the individual mandate in the first half of 2012. We cannot predict the outcome of these proceedings or certain legislative efforts in Congress that may attempt to withhold funding necessary to implement the Health Care Reform Legislation, amend the legislation or repeal it.

Depending on the outcome of certain potential developments with respect to the Health Care Reform Legislation, including but not limited to those mentioned above, certain elements of this legislation could have a material adverse effect on our financial condition and results of operations. In addition, a number of state legislatures have enacted or are contemplating significant health insurance reforms, either in response to the Health Care Reform Legislation or independently (to the extent not addressed by federal legislation). The Health Care Reform Legislation, as well as state health insurance reforms, could increase our costs, require us to revise the way in which we conduct business, result in the elimination of certain products or business lines (including, potentially, non-renewal of our existing health benefit plan business in one or more states subject to applicable state and federal requirements), lead to lower revenues and expose us to an increased risk of liability. Any delay or failure to conform our business to the requirements of the Health Care Reform Legislation and state health insurance reforms could disrupt our operations, lead to regulatory issues, damage our relationship with existing customers and our reputation generally, adversely affect our ability to attract new customers and result in other adverse consequences.

With respect to the minimum loss ratio requirements effective beginning in 2011, a mandated minimum loss ratio of 80% for the individual and small group markets is expected to have a significant impact on the revenues of our insurance subsidiaries and our business generally. Historically, the Company has experienced significantly lower medical loss ratios, has not been able to price premiums for its individual health insurance policies at this level and may not be able to operate profitably at an 80% minimum medical loss ratio. As a result of these requirements, our insurance subsidiaries have reduced the level of commissions paid to the agents who distribute their health benefit plans which may, in part, mitigate the impact of the minimum loss ratio requirements. The 80% minimum medical loss ratio for the individual market is subject to adjustment by the Department of Health and Human Services (HHS), on a state-by-state basis, if HHS determines that the requirement is disruptive to the market. For example, in response to a request by the Maine Bureau of Insurance (MBI), on March 8, 2011, HHS granted an adjustment to the MLR standard applicable to the individual health insurance market in Maine. As a result, the 80% MLR standard will be adjusted to 65% for the reporting years 2011, 2012 and 2013 (with the adjustment for 2013 subject to MBI providing updated data in 2012 that indicate a continued need for such an adjustment). In granting the adjustment, HHS agreed with the reasoning that led to MBI s conclusion that application of the 80% MLR standard in Maine has a reasonable likelihood of destabilizing the Maine individual health insurance market. A number of other states have requested similar waivers. HHS has approved some of these requested waivers and denied others. HHS has issued final rules addressing certain material aspects of the MLR requirements, including those which help define which expenses should be classified as medical and which should be classified as non-medical for purposes of the calculation and which taxes, fees and assessments may be excluded from premium calculations. The Company s review of these rules is ongoing, but a minimum medical loss ratio at or near the 80% level could, at an appropriate time in the future, compel us to issue rebates to customers, discontinue the underwriting and marketing of individual health insurance and/or non-renew coverage of our existing individual health customers in one or more states subject to applicable state and federal requirements.

In addition, beginning in 2011, the mandated medical loss ratio requirements have adversely affected the level of base commissions and override commissions that Insphere receives from the Company s insurance subsidiaries and third party insurance carriers. In order to comply with the 80% minimum medical loss ratio requirement, many of these carriers, including the Company s insurance subsidiaries, have reduced commissions

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and overrides. In the fourth quarter of 2010, Insphere received notice from a number of its health carriers that compensation levels in 2011 would be significantly lower than 2010 levels. As a result of these reductions, Insphere has lowered the level of commissions paid to its agents for the sale of products underwritten by these carriers and the impact of these reductions has been significant.

To the extent required by the Health Care Reform Legislation, the Company has made the adjustments to its in-force block of business issued prior to March 24, 2010, including but not limited to removal of lifetime caps on benefits, extension of dependent coverage through age 26, meeting new HHS reporting requirements and adopting limitations on most policy rescissions. These changes generally became effective on January 1, 2011 (for most of our plans - the effective date of the new plan year), although certain states required an earlier effective date. In addition to the changes discussed above, plans issued on or after March 24, 2010 are subject to more extensive benefit changes, including but not limited to first dollar preventive care benefits and no annual limits on essential benefits covered by the policies. The Company made all state form and rate filings necessary to include these new requirements and, effective in September 2011, made required rate and form changes for new policies marketed after that date. The Company s review of the requirements of the Health Care Reform Legislation, and its potential impact on the Company s health insurance product offerings, is ongoing.

Health Insurance Product Sales

As a result of the enactment of Health Care Reform Legislation, as well as the growing emphasis on the distribution of third party products through Insphere, in the second quarter of 2010, the Company determined that it would discontinue the sale of the Company s traditional scheduled benefit health insurance products. After September 23, 2010, the effective date for many aspects of the Health Care Reform Legislation, the Company discontinued marketing all of its health benefit plans in all but a limited number of states in which Insphere does not currently have access to third-party health benefit plans. (See Commercial Health Division Health Insurance Products discussion above).

State Insurance Regulation

HealthMarkets Insurance Subsidiaries

Our insurance subsidiaries and the products they offer are subject to extensive regulation in their respective state of domicile and the other states in which they do business. Insurance statutes typically delegate broad regulatory, supervisory and administrative powers to each state s commissioner of insurance. 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, including with respect to the protection of consumers; disclosure requirements; privacy standards; minimum loss ratios; premium rate regulation; underwriting standards; approval of policy forms and mandating benefits with respect to certain medical conditions or procedures; claims payment practices, including prompt payment of claims and independent external review of certain coverage decisions; licensing of insurance agents and the regulation of agent conduct; the amount and type of investments that the insurance subsidiaries may hold; minimum reserve and surplus requirements; risk-based capital requirements; and mandatory participation in, and assessments for, risk sharing pools and guaranty funds. Such regulation is intended to protect policyholders rather than investors. The level and scope of these state regulatory activities may be impacted by Health Care Reform Legislation. For example, we expect that state policies with respect to premium rate increases will become more restrictive as a result of the Health Care Reform Legislation.

To the extent not addressed by federal legislation, various states have, from time to time, proposed and/or enacted changes to the health care system that could affect the relationship between health insurers and their customers. For example, Massachusetts 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

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insurance to these employees. Other states have adopted or proposed laws intended to require minimum levels of health insurance for previously uninsured residents, including play or pay laws requiring that employers either offer health insurance or pay a tax to cover the costs of public health care insurance. We expect state legislatures to continue pursuing such initiatives, depending on whether changes of this nature occur in connection with national health care reform. We cannot predict with certainty the effect that proposed state legislation, if adopted, could have on our insurance businesses and operations.

The states in which our insurance subsidiaries are licensed have the authority to change the minimum mandated 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. To the extent not addressed by federal legislation, a number of states are considering the adoption of, or have adopted, laws that would mandate minimum loss ratios, or increase existing minimum loss ratios, for our health benefit plans. States may also adopt minimum loss ratios applicable to health benefit plans that are higher than those established by federal legislation, or applicable to supplemental insurance products that are generally not subject to Health Care Reform Legislation. We expect state legislatures to continue pursuing such initiatives, depending on whether changes in minimum loss ratios occur in connection with national health care reform. Certain of these changes could have a material adverse effect on our financial condition and results of operations by resulting in a narrowing of profit margins or preventing us from doing business in certain states. We evaluate legislative developments regarding mandatory loss ratios and other matters on an ongoing basis. If we determine that the legislative or regulatory environment in a particular state prevents us from doing business in the state on a profitable basis, we may determine that it is in the Company s best interest to cease doing business in that state.

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 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, Inc. (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, 2011, the risk-based capital ratio of each of our insurance subsidiaries exceeded the ratio for which regulatory corrective action would be required. 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.

Insphere Insurance Solutions

Insphere and its independent agents are authorized to distribute insurance products in all 50 states and the District of Columbia and must maintain applicable agency and/or agent licenses. Licensing laws and regulations vary by individual state and are often complex and are subject to amendment or reinterpretation by state regulatory authorities. State insurance departments have relatively broad discretion to grant, revoke, suspend and renew licenses required by Insphere and/or its agents to conduct business. State insurance departments also have the authority to regulate advertising, marketing and trade practices, monitor agent conduct, impose continuing

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education requirements and limit the amount and/or type of commission paid to agents. Failure to comply with laws and regulations applicable to insurance agents could subject Insphere and/or its agents to fines and penalties or result in suspension of activity in, or exclusion from, a particular state.

Various state insurance laws and regulations restrict or limit the manner in which health insurance plans and supplemental health products may be offered, marketed or sold. Life products, long-term-care products, disability products and annuities are subject to additional marketing laws and regulations, such as requirements for disclosures or prohibiting certain terminology during marketing presentations. Failure to comply with all applicable marketing laws and regulations could subject Insphere and its agents to fines, penalties, cease and desist orders, and loss of licensure by state insurance departments and by some state attorneys general, as well as result in possible litigation exposure for Insphere and its agents. We expect Insphere to begin marketing additional product lines in the future which will present additional regulatory requirements on Insphere and its agents.

State 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 Oklahoma Insurance Department (the domiciliary regulator of MEGA, Chesapeake and HealthMarkets Insurance Company (HMIC)) and the Texas Department of Insurance (the domiciliary regulator of Mid-West) conduct regularly scheduled financial exams of the insurance subsidiaries. On July 27, 2010, the Oklahoma Department of Insurance commenced a triennial financial examination of MEGA, Chesapeake and HMIC for the exam period ended December 31, 2009 which concluded in June 2011 with no material findings. In the first quarter of 2012, the Texas Department of Insurance commenced a regularly scheduled financial examination of Mid-West and Fidelity First Insurance Company for the five year period ended December 31, 2011.

State insurance departments periodically conduct, and will continue to conduct, market conduct examinations of HealthMarkets insurance subsidiaries. As reported in Note 16 of the Notes to Consolidated Financial Statements, such examinations have included the multi-state market conduct examination of MEGA, Mid-West and Chesapeake and the market conduct examination of MEGA, Mid-West and Chesapeake by the Massachusetts Division of Insurance, which was settled on August 26, 2009. In addition to the examinations reported in Note 16, the Company s insurance subsidiaries are subject to various other pending market conduct and other regulatory examinations, inquiries or proceedings arising in the ordinary course of business. In addition, Insphere could be subject to a market conduct examination as a result of its sales activities with respect to a non-affiliated insurance company. State insurance regulatory agencies have authority to levy significant fines and penalties and require remedial action resulting from findings made during the course of such matters. Market conduct or other regulatory examinations, inquiries or proceedings could result in, among other things, changes in business practices that require the Company to incur substantial costs. Such results, individually or in combination, could injure the Company s reputation, cause negative publicity, adversely affect the Company s debt and financial strength ratings, place the Company at a competitive disadvantage in marketing or administering its products or impair the Company s ability to sell insurance policies or retain customers, thereby adversely affecting its business, and potentially materially adversely affecting the results of operations in a period, depending on the results of operations for the particular period. Determination by regulatory authorities that the Company has engaged in improper conduct could also adversely affect its defense of various lawsuits.

Federal Regulation

In addition to Health Care Reform Legislation, federal legislation and administrative policies in several areas - including the Medicare program, HIPAA, ERISA, pension regulation, age and sex discrimination, financial services regulation, securities regulation, privacy laws, terrorism and federal taxation - affect the insurance business. While the Company has taken what it believes are reasonable steps to ensure that it is in full compliance with these requirements, failure to comply could result in regulatory fines and civil lawsuits.

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HIPAA and Other Privacy Regulations

The use, disclosure and secure handling of individually identifiable health information by our business is subject to federal regulations, including the privacy provisions of the federal Gramm-Leach-Bliley Act and the privacy and security regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In addition, our privacy and security practices are subject to various state laws and regulations. HIPAA includes requirements for maintaining the confidentiality and security of individually identifiable health information and standards for electronic health care transactions. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) was enacted into law as part of the American Recovery and Reinvestment Act of 2009. The HITECH Act contains a number of provisions that significantly expand the reach of HIPAA. For example, the law imposes varying civil monetary penalties and creates a private cause of action for HIPAA violations, extends HIPAA s security provisions to business associates, and creates new security breach notification requirements. In January 2009, the Department of Health and Human Services proposed new rules that would modify the current ICD-9 medical data code set standards and adopt new standards known as ICD-10 code sets, and would make related changes to the current HIPAA electronic transaction standards. The compliance date of the new ICD-10 code sets is October 1, 2013. In February 2012, the Company implemented the updated electronic transaction standards which were required to be in compliance by March 1, 2012. We expect that the new standards required by these rules will require implementation of new software and changes to our systems and processes, the cost of which may be significant. As have other entities in the health care industry, we have incurred substantial costs in meeting the requirements of the HIPAA regulations and expect to continue to incur costs to maintain compliance. HIPAA and other federal and state privacy regulations continue to evolve as a result of new legislation, regulations and judicial and administrative interpretations. Consequently, our efforts to measure, monitor and adjust our business practices to comply with these requirements are ongoing. In addition to obligations on the part of the Company s insurance subsidiaries, Insphere serves as a business associate of the Company s insurance subsidiaries as well as non-affiliated insurance companies with which it does business. Insphere s relationship with these non-affiliated insurance companies has added complexity to the Company s privacy compliance obligations. 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.

In addition to imposing privacy requirements, HIPAA also 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. These aspects of HIPAA are regulated not only by federal laws and regulations, but also by state laws implementing HIPAA s requirements. The Company and its agents are required to comply with these HIPAA requirements when marketing products to individuals or at a place of business.

CAN SPAM Act and Do Not Call Regulations

From time to time, the Company utilizes, either directly or through third party vendors, e-mail and telephone calls to identify prospective sales leads for use by our agents. The federal CAN SPAM Act, administered and enforced by the Federal Trade Commission, establishes national standards for sending bulk, unsolicited commercial e-mail. The Company is also required to comply with federal Do Not Call regulations, enforced by the Federal Communications Commission, and other federal and state regulations regarding telemarketing, which require, among other things, that insurers and insurance agencies develop their own do not call lists and reference state and federal do not call registries before making calls to market insurance products. The Do Not Call regulations also contain prohibitions on unsolicited facsimiles. Insphere s agents are trained to comply with these requirements when marketing insurance products and association memberships. Failure to comply could result in enforcement actions by state attorneys general, regulatory fines and penalties and civil lawsuits.

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USA PATRIOT Act

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. The Office of Federal Asset Control requirements prohibit business dealings with entities identified as threats to national security. We have licensed software designed to help maintain compliance with these requirements and we continually evaluate our policies and procedures to comply with these regulations.

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.

Medicare

Insphere and its agents are subject to federal regulations as a result of the marketing of certain Medicare products for a non-affiliated insurance carrier. Medicare is a complex and highly regulated federal program that provides eligible persons age 65 and over and some disabled persons a variety of hospital and medical insurance benefits. Failure to comply with applicable Medicare regulations could subject Insphere and its agents to a variety of fines and penalties.

Legislative Developments

In addition to the changes resulting, or expected to result, from National Health Care Reform Legislation, the federal and state governments continue to consider legislative and regulatory proposals that could materially impact health insurance companies and various aspects of the current health care system. Many of these proposals attempt to reduce the number of uninsured by increasing affordability and expanding access to health insurance. Some of the more significant legislative and regulatory developments that could potentially affect our business include the following:

Requiring employers to provide health insurance to employees;

Requiring individuals to purchase health insurance coverage;

Establishing a minimum level of coverage required to satisfy health insurance mandates;

Establishing minimum loss ratios that require insurers to pay a minimum amount of claim payments as a percentage of premiums received;

Mandating coverage of certain conditions or specified procedures, drugs and devices;

Standardizing individual health insurance so as to restrict the ability of health insurers to significantly vary coverage, including the health care services considered to be covered or excluded, deductible and cost-sharing levels and coverage limits; and

Extending malpractice and other liability exposure for decisions made by health insurers.

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In addition, the NAIC has adopted final revisions to the Annual Financial Reporting Model Regulation which address corporate governance and internal control over financial reporting issues, similar to the Sarbanes-Oxley Act of 2002, which certain of our insurance subsidiaries must comply with.

We expect the trend of increased legislative activity to continue and cannot predict with certainty the effect that such proposals, if adopted, could have on our health insurance business and operations. Changes in health care policy could significantly affect our business. Certain of the proposals, if adopted, could have a material adverse effect on our financial condition and results of operations.

Employees

We have approximately 700 employees at December 31, 2011. As discussed above in Commercial Health Division Health Insurance Products, the Company has been pursuing initiatives to significantly reduce administrative expenses and initiatives of this nature may continue in the future. Since 2008, the Company has experienced a series of reductions to its workforce designed to better align this workforce to current business levels, properly manage the Company s expenses and support the Company s business strategy going forward. We believe that the Company s relations with its remaining employees are generally good.

Executive Officers of the Company

The Chairman of the Company and all other executive officers listed below are elected by the Board of Directors of the Company at its Annual Meeting each year 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
Kenneth J. Fasola	Director, President and Chief Executive Officer	52	Mr. Fasola joined the Company in September 2010 as Director, President and Chief Operating Officer. He has served as Chief Executive Officer since April 2011. He also serves as a Director, President and CEO of the Company s insurance subsidiaries and of the Company s Insphere insurance agency subsidiary. From October 2009 to September 2010, Mr. Fasola held several executive and senior level management positions at Humana. Mr. Fasola served as Chief Executive Officer of Secure Horizons, the nation s largest Medicare Advantage insurer, from February 2007 to September 2008; as CEO of UnitedHealth Group s Central Region from August 2004 to February 2007, and as President of United Healthcare Lines of Business from January 2003 to August 2004. Mr. Fasola began his insurance career in sales with Blue Cross of Central Ohio before moving to Community Mutual Blue Cross and Blue Shield in Ohio where he served in sales management positions. Mr. Fasola serves on the advisory board of Pennsylvania State University, Schreyer Honors College and previously served on the board of Connextions, Inc., a technology-based business process outsourcing firm.

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Name of Officer	Principal Position	Age	Business Experience During Past Five Years
K. Alec Mahmood	Senior Vice President and Chief Financial Officer	41	Mr. Mahmood joined the Company in June 2007 as Senior Vice President of Budget, Planning and Analysis. He serves as Senior Vice President of the Company and was appointed to Chief Financial Officer on October 1, 2010. He currently serves as a Director, Senior Vice President and Chief Financial Officer of the Company s insurance subsidiaries. He also serves as Senior Vice President, Chief Financial Officer and Treasurer of the Company s Insphere insurance agency subsidiary. From July 2005 to April 2007, Mr. Mahmood held several senior level management positions at Coventry HealthCare, Inc., including Chief Operating Officer and Chief Financial Officer, Medicaid Division (Healthcare USA) and General Manager, Medicare Special Needs Plans Division. Mr. Mahmood served as Vice President of Financial Operations of Ardent Health Services, from 2003 to 2005. Prior to Ardent, Mr. Mahmood was at Health Net Inc. from 1999 - 2003 and served as Chief Financial Officer of Health Net s Arizona Division and of its behavioral health subsidiary, MHN.
Derrick A. Duke	Senior Vice President, Treasurer and Chief Insurance Operating Officer	45	Mr. Duke joined the Company in May 2004 as Vice President and Chief Investment Officer. He currently serves as Senior Vice President, Treasurer and Chief Insurance Operating Officer of the Company. Mr. Duke also serves as a Director, Senior Vice President, Treasurer and Chief Investment Officer of the Company s insurance subsidiaries. Prior to joining the Company, Mr. Duke served as Senior Vice President and Chief Investment Officer for a privately held insurance company from June 1989 to May 2004.
Mark H. Smith	Senior Vice President, Chief Operating Officer Insphere Insurance Solutions, Inc.	47	Mr. Smith joined the Company s Insphere insurance agency subsidiary in October 2011 as Senior Vice President and Chief Operating Officer. From February 2010 until joining Insphere, he served as National Practice Leader for UnitedHealthcare s Small Group Division and as Regional Vice President from July 2007 to February 2010. From July 2001 to July 2007, Mr. Smith was part of the management team that launched Destiny Health, the U.S. based company that is a wholly owned subsidiary of Discovery Health. Prior thereto, he served as National Vice President of Distribution for Discovery Health, a South African insurance company.

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Item 1A. ***Risk Factors***

The following factors could impact our business and financial prospects:

Certain elements of national health care reform legislation could potentially have a material adverse effect on our financial condition and results of operations

In March 2010, Health Care Reform Legislation was signed into law, which will result in broad-based material changes to the United States health care system. The Health Care Reform Legislation has, and is expected to continue to, significantly impact our business, including but not limited to the minimum medical loss ratio requirements applicable to our insurance subsidiaries as well to health insurance carriers doing business with Insphere. While not all-inclusive, the following material provisions of the Health Care Reform Legislation are subject to ongoing evaluation by the Company:

- establishment of a minimum medical loss ratio of 80% for the individual and small group markets beginning in 2011, with rebates to customers required for medical loss ratio amounts under the minimum;
- expansion of dependent coverage to include adult children up to age 26;
- elimination of most annual and all lifetime caps on benefits;
- elimination of pre-existing condition exclusions for certain dependents;
- requirements that limit the ability of health insurance providers to vary premium based on assessment of underlying risk;
- payment of first dollar preventive care benefits for non-grandfathered business;
- establishment of specific benefit design requirements, rating and pricing limits and guaranteed issue requirements;
- obligation to add coverage for mandated essential benefits for non-grandfathered plans (currently expected to be effective in 2014);
- creation of health insurance exchanges (currently expected to be effective in 2014) with standardized plans and potential guarantee issue of coverage requirements for the individual and small group markets, which plans may be an attractive option for our existing customers and cause them to cancel their coverage with us;
- prohibitions on most policy rescissions;
- significant annual taxes and/or assessments on health insurance providers which may not be deductible for income tax purposes; and

limitations on the deductibility of executive compensation under Section 162(m) of the Internal Revenue Code for health insurance providers.

Provisions of the Health Care Reform Legislation become effective at various dates over the next several years and a number of additional steps are required to implement these requirements, including, without limitation, further guidance and clarification in the form of final implementing regulations for certain key aspects of the legislation. Due to the complexity of the Health Care Reform Legislation, gradual implementation and pending status of certain guidance and regulations, the full impact of Health Care Reform Legislation on our business is not yet fully known. However, we have dedicated material resources and, in the future, expect to dedicate additional material resources and to incur material expenses (including but not limited to additional claims expenses) as a result of Health Care Reform Legislation.

In addition, the Health Care Reform Legislation has been the subject of litigation in a number of federal district courts challenging the constitutionality of all or certain aspects of the legislation including, among other things, the individual mandate element of the legislation which requires individuals to purchase health insurance coverage or be subject to penalties. The United States Supreme Court is expected to review certain

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aspects of the Health Care Reform Legislation, including the constitutionality of the individual mandate in the first half of 2012. We cannot predict the outcome of these proceedings or certain legislative efforts in Congress that may attempt to withhold funding necessary to implement the Health Care Reform Legislation, amend the legislation or repeal it.

Depending on the outcome of certain potential developments with respect to the Health Care Reform Legislation, including but not limited to those mentioned above, certain elements of this legislation could have a material adverse effect on our financial condition and results of operations. In addition, a number of state legislatures have enacted or are contemplating significant health insurance reforms, either in response to the Health Care Reform Legislation or independently (to the extent not addressed by federal legislation). The Health Care Reform Legislation, as well as state health insurance reforms, could increase our costs, require us to revise the way in which we conduct business, result in the elimination of certain products or business lines (including, potentially, non-renewal of our existing health benefit plan business in one or more states subject to applicable state and federal requirements), lead to the lower revenues and expose us to an increased risk of liability. Any delay or failure to conform our business to the requirements of the Health Care Reform Legislation and state health insurance reforms could disrupt our operations, lead to regulatory issues, damage our relationship with existing customers and our reputation generally, adversely affect our ability to attract new customers and result in other adverse consequences.

With respect to the minimum loss ratio requirements effective beginning in 2011, a mandated minimum loss ratio of 80% for the individual and small group markets is expected to have a significant impact on the revenues of our insurance subsidiaries and our business generally. Historically, the Company has experienced significantly lower medical loss ratios, has not been able to price premiums for its individual health insurance policies at this level and may not be able to operate profitably at an 80% minimum medical loss ratio. As a result of these requirements, our insurance subsidiaries have reduced the level of commissions paid to the agents who distribute their health benefit plans which may, in part, mitigate the impact of the minimum loss ratio requirements. The 80% minimum medical loss ratio for the individual market is subject to adjustment by the Department of Health and Human Services (HHS), on a state-by-state basis, if HHS determines that the requirement is disruptive to the market. HHS has issued final rules addressing certain material aspects of the MLR requirement, including those which help define which expenses should be classified as medical and which should be classified as non-medical for purposes of the calculation and the taxes, fees and assessment which may be excluded from premium calculations. The Company s review of these rules is ongoing, but a minimum medical loss ratio at or near the 80% level could, at an appropriate time in the future, compel us to issue rebates to customers, discontinue the underwriting and marketing of individual health insurance and/or non-renew coverage of our existing individual health customers in one or more states subject to applicable state and federal requirements.

In addition, beginning in 2011, the mandated medical loss ratio requirements have adversely affected the level of base commissions and override commissions that Insphere receives from the Company s insurance subsidiaries and third party insurance carriers. In order to comply with the 80% minimum medical loss ratio requirement, many of these carriers, including the Company s insurance subsidiaries, have reduced commissions and overrides. In the fourth quarter of 2010, Insphere received notice from a number of its health carriers that compensation levels in 2011 would be significantly lower than 2010 levels. As a result of these reductions, Insphere has lowered the level of sales commissions paid to its sales force for the sale of products underwritten by these carriers and the impact of these reductions has been significant.

The Company s review of the requirements of the Health Care Reform Legislation described above, and its potential impact on the Company s health insurance product offerings, is ongoing.

National health care reform legislation could increase our cost structure and impede our ability to obtain premium rate increases necessary to offset these costs.

Several aspects of the Health Care Reform Legislation are expected to increase our costs, including but not limited to the elimination of most annual and all lifetime caps on the dollar value of benefits, the elimination of

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pre-existing condition exclusions and the obligation to add coverage for mandated essential benefits for non-grandfathered plans. Premium increases will be necessary to mitigate the impact these and other provisions of the Health Care Reform Legislation will have on our cost structure. Premium increases are generally subject to the approval of state insurance departments. In addition, HHS rules establish a federal premium rate review process for annual premium rate increases (generally, of 10% or more), which could make it more difficult to obtain approval of premium rate increases. The inability of our insurance companies to increase premiums rates to offset increases in their cost structure could have a material adverse effect on our financial condition and results of operations.

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

We conduct business in a heavily regulated industry. In addition to the national health care reform legislation discussed above, to the extent not addressed by federal legislation, various states have, from time to time, proposed and/or enacted changes to the health care system that could affect the relationship between health insurers and their customers (see Item 1. Business Regulatory and Legislative Matters for additional information). Many of these proposals attempt to reduce the number of uninsured by increasing affordability and expanding access to health insurance. Proposals include changes to minimum mandated loss ratios, the manner in which these ratios are computed and the manner in which compliance with these ratios is measured and enforced. To the extent not addressed by federal legislation, a number of states are considering the adoption of, or have adopted, laws that would mandate minimum loss ratios, or increase existing minimum loss ratios, for our health benefit plans. States may also adopt minimum loss ratios applicable to health benefit plans that are higher than those established by federal legislation, or applicable to supplemental insurance products that are generally not subject to Health Care Reform Legislation. We expect state legislatures to continue pursuing such initiatives, depending on whether changes in minimum loss ratios occur in connection with national health care reform. Certain of these changes could have a material adverse effect on our financial condition and results of operations by resulting in a narrowing of profit margins or preventing us from doing business in certain states.

Some of the more significant additional legislative and regulatory developments that could potentially affect our business include the following:

- Requiring employers to provide health insurance to employees;
- Requiring individuals to purchase health insurance coverage;
- Establishing a minimum level of coverage required to satisfy health insurance mandates;
- Mandating coverage of certain conditions or specified procedures, drugs and devices;
- Standardizing individual health insurance so as to restrict the ability of health insurers to significantly vary coverage, including the health care services considered to be covered or excluded, deductible and cost-sharing levels and coverage limits; and
- Extending malpractice and other liability exposure for decisions made by health insurers.

We expect state legislatures to continue pursuing such initiatives, depending on whether changes of this nature occur in connection with national health care reform. We cannot predict with certainty the effect that proposed state legislation, if adopted, could have on our insurance businesses and operations. Changes in health care policy could significantly affect our business. Certain of these proposals, if adopted, could have a material adverse effect on our financial condition and results of operations. Changes in the level of government regulation or in the laws and regulations themselves could substantially increase the costs of compliance and result in significant changes to our operations. If we determine that the legislative or regulatory environment in a particular state prevents us from doing business in the state on a profitable basis, we may determine that it is in the Company s best interest to cease doing business in that state.

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Failure to comply with extensive state and federal regulations could subject us to fines, penalties and suspensions, which could have a material adverse effect on our financial condition and results of operations.

We are subject to extensive governmental regulation and supervision (see Item 1. Business Regulatory and Legislative Matters for additional information). 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:

- licensing of insurers and their agents;
- sales and marketing practices;
- training and oversight of agents;
- handling of consumer complaints and grievances;
- approval of policy forms and premium rates;
- standards of solvency, including risk-based capital measurements, which are a measure developed by the NAIC and used by state insurance regulators to identify insurance companies that potentially are inadequately capitalized;
- 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 through, among other things, financial and market conduct examinations, and require the filing of annual and other reports relating to the financial condition of insurance companies, holding company issues and other matters. Regulatory agencies have imposed substantial fines against us in the past, and may impose substantial fines against us in the future if they determine that we have not complied with applicable laws and regulations (see Note 16 to Notes to Consolidated Financial Statements).

There is also substantial federal regulation of our business. Laws and regulations adopted by the federal government, including the Sarbanes-Oxley Act of 2002, the Gramm-Leach-Bliley Act, HIPAA, the USA PATRIOT Act and the CAN SPAM and Do Not Call regulations, establish administrative and compliance requirements applicable to the Company.

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 which, depending on the nature of the penalty, 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.

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Current or future state and federal regulations could impede our ability to obtain effective leads and adversely affect our business

We utilize, either directly or through third party vendors, e-mails and telephone calls to identify prospective sales leads for use by our agents. Lead generation activities are subject to state and federal regulations, including, but not limited to, the federal CAN SPAM Act (which establishes national standards for sending bulk, unsolicited commercial e-mail) and the federal Do Not Call regulations and state regulations regarding telemarketing (which require companies including insurers and insurance agencies to develop their own do not call lists and reference state and federal do not call registries before making calls to market insurance products, and prohibit unsolicited facsimiles) (see Item 1. Business Regulatory and Legislative Matters for additional information). Failure to comply could result in enforcement actions by state attorneys general, regulatory fines and penalties and civil lawsuits. We believe that our ability to obtain quality sales leads plays a significant role in the generation of new business and our efforts to recruit and retain effective agents. To the extent that laws currently in effect, or passed in the future, make it more difficult or costly for us to obtain effective leads, or eliminate our ability to purchase or generate leads, our business could be materially and adversely affected.

We must comply with restrictions on customer privacy and information security, including taking steps to ensure compliance by our business associates with HIPAA.

The use, disclosure and secure handling of individually identifiable health information by our business is subject to state and federal law and regulations, including the privacy provisions of the federal Gramm-Leach-Bliley Act and the privacy and security regulations promulgated under HIPAA (See Item 1. Business Regulatory and Legislative Matters for additional information). The HIPAA regulations establish significant criminal penalties and civil sanctions for non-compliance. The HIPAA regulations require, among other things, that we enter into specific written agreements with business associates to whom individually identifiable health information is disclosed. Although our contracts with business associates provide for appropriate protections of such information, we may have limited control over the actions and practices of our business associates. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) was enacted into law on February 17, 2009 as part of the American Recovery and Reinvestment Act of 2009. The HITECH Act contains a number of provisions that significantly expand the reach of HIPAA, including imposition of varying civil monetary penalties, creation of a private cause of action for HIPAA violations, extension of HIPAA s security provisions to business associates and creation of new security breach notification requirements. Compliance with HIPAA, the HITECH Act and other state and federal privacy and security regulations have required us to implement changes in our programs and systems to maintain compliance and may in the future result in significant expenditures due to necessary systems changes, the development of new administrative processes and the effects of potential noncompliance by our business associates. In addition to obligations on the part of the Company s insurance subsidiaries, Insphere serves as a business associate of the non-affiliated insurance companies with which it does business. Insphere s relationship with these non-affiliated insurance companies has added complexity to the Company s privacy compliance obligations. 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.

Failure to comply with the terms of the regulatory settlement agreement arising out of the multi-state market conduct examination of our principal insurance subsidiaries could have a material adverse effect on our financial condition and results of operations.

In March 2005, we received notification that the Market Analysis Working Group of the NAIC had chosen the states of Washington and Alaska to lead a multi-state market conduct examination of our principal insurance subsidiaries, MEGA, Mid-West and Chesapeake (the Insurance Companies). On May 29, 2008, the Insurance Companies entered into a regulatory settlement agreement (RSA) with the states of Washington and Alaska, as lead regulators, and three other states (collectively, the Monitoring Regulators). Thereafter, all states and the District of Columbia, Puerto Rico and Guam signed the RSA (other than Massachusetts and Delaware), which became effective on August 15, 2008. In connection with the RSA, the Insurance Companies paid a penalty of

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$20 million. The RSA includes standards for performance measurement for 13 different required actions which were required to be implemented on or before December 31, 2009. The Insurance Companies filed the last of the semi-annual reports required by the RSA on February 15, 2010 and have taken actions to meet all the standards of the RSA on or before the due date. In 2010, the Insurance Companies furnished information responsive to requests by the Monitoring Regulators and responded to comments by the Monitoring Regulators. In the first quarter of 2011, the Monitoring Regulators initiated a re-examination to assess the Insurance Companies performance with respect to RSA standards. Field work for the re-examination was completed in July 2011, the Company received a draft report regarding the re-examination from the Monitoring Regulators in October 2011 and the Company responded to the draft report in November 2011 and requested a hearing which is currently scheduled to occur in April 2012. If the re-examination is unfavorable, the Insurance Companies are subject to additional penalties of up to $10 million. See Note 16 of Notes to Consolidated Financial Statements.

The Insurance Companies have periodically been the subject of other market conduct examinations conducted by state insurance departments. As reported in Note 16 of Notes to Consolidated Financial Statements, such examinations have included the market conduct examination of MEGA, Mid-West and Chesapeake by the Massachusetts Division of Insurance, resulting in a 2006 regulatory settlement agreement, and subsequent re-examination of certain key provisions of the regulatory settlement agreement commencing in January 2009, which was settled on August 26, 2009.

The Insurance Companies are subject to various other pending market conduct and other regulatory examinations, inquiries or proceedings arising in the ordinary course of business. State insurance regulatory agencies have authority to levy significant fines and penalties and require remedial action resulting from findings made during the course of such matters. Market conduct or other regulatory examinations, inquiries or proceedings could result in, among other things, changes in business practices that require the Company to incur substantial costs. Such results, singly or in combination, could injure our reputation, cause negative publicity, adversely affect our debt and financial strength ratings, place us at a competitive disadvantage in marketing or administering our products or impair our ability to sell or retain insurance policies, thereby adversely affecting our business, and potentially materially adversely affecting the results of operations in a period, depending on the results of operations for the particular period. Determination by regulatory authorities that we have engaged in improper conduct could also adversely affect our defense of various lawsuits.

We may lose business to competitors

We compete, and will continue to compete, for customers with many other companies, including insurance companies, insurance agencies and other financial services companies. 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 and have lower cost structures. Some may also have greater financial resources with which to compete. With respect to our Commercial Health division, other insurers may have higher financial strength or claims paying ratings, or may be able to obtain more favorable financial arrangements from healthcare providers that are not available to us, which may make their health benefit plan offerings more attractive than our own. Other companies enter and exit the markets in which we operate, thereby increasing competition at times when there are new entrants. For example, we currently believe that Chesapeake offers one of the largest portfolios of individual supplemental products in the market. However, as a result of the Health Care Reform Legislation, we expect the supplemental insurance business to become a greater area of focus for other insurance carriers. Competitors in the supplemental market may include insurance carriers who have substantially greater revenues, capital resources or product and geographic market coverage. Entry into the supplemental market, or expansion of existing supplemental business, by such competitors could adversely affect our ability to successfully market supplemental products on a competitive basis and decrease revenues arising from the sale of supplemental products.

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Failure to recruit and retain agents could prevent us from competing successfully and could have a material adverse effect on our financial condition and results of operations.

We compete not only for the business of customers, but also for agents and distribution relationships with other distributors and insurance companies. We distribute our products as well as the products of non-affiliated insurance companies through independent agents contracted with Insphere. Insphere s business is highly competitive and there are many insurance agencies, brokers and intermediaries who actively compete with us. We also compete with insurance companies that sell their products directly to customers and do not use or pay commissions to third-party agents or brokers. In addition, the Internet continues to be a source for direct placement of business and creates competition for Insphere. We compete for productive agents with other distributors based on a number of factors, including compensation structure, level of training and support services and product offerings. It can be difficult to successfully compete for agents with companies that have greater revenues, capital resources, product and geographic market coverage or name recognition.

The Health Care Reform Legislation may adversely affect Insphere s ability to recruit and retain agents. As a result of certain changes arising from this legislation, including the 80% minimum medical loss ratio requirement, many of the carriers with which Insphere does business, including the Company s insurance subsidiaries, have reduced commissions and overrides. In the fourth quarter of 2010, Insphere received notice from a number of its health carriers that compensation levels in 2011 would be significantly lower than 2010 levels. As a result, commission levels to the Insphere distribution force have been reduced, which could potentially make it more difficult for Insphere to recruit agents and/or retain agents who are unable to earn sufficient income at the reduced commission levels.

Insphere s business model requires near term growth in the number of productive selling agents within its sales force and the retention of these agents. Any inability by Insphere to recruit, retain and expand the number of productive insurance agents within its sales force could adversely affect Insphere s business prospects and could have a material adverse effect on our financial condition and results of operations.

Changes in our relationship with membership associations, or changes in association product benefits, could have a material adverse effect on our financial condition and results of operations.

Historically, a substantial portion of the products offered by our insurance subsidiaries were issued to members of independent membership associations that act as the master policyholder for such products. The associations provide their members with access to a number of benefits and products, including health insurance underwritten by the HealthMarkets insurance subsidiaries. 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. In the limited number of states where the Company s insurance subsidiaries currently continue to offer its health benefit plans, these plans are now offered to the individual market directly and not through the associations. In addition, Insphere maintains agreements with independent membership associations - AAS and AFS - pursuant to which Insphere s agents act as field service representatives for the associations. These agreements provide Insphere with the exclusive right to distribute association products for AAS and AFS. In this capacity, Insphere s agents enroll new association members and provide membership retention services. Insphere receives compensation from the associations, including fees associated with enrollment, member retention services, marketing and administrative services.

An adverse change in our relationship with these associations, including but not limited to a termination of our agreements with these associations, could be fundamentally disruptive to our in-force block of health benefit plan business issued to members of independent membership associations and could result in the termination or non-renewal of some or all of this business. Such a change could also adversely affect Insphere s efforts to market association products. Changes in the nature of the association products offered, including benefits, could also adversely affect Insphere s business.

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Negative publicity regarding our business practices and about the health insurance industry in general may harm our business and could have a material adverse effect on our financial condition and results of operations.

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 regarding the industry generally or our Company in particular may result in increased regulation and legislative scrutiny 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. Certain of the matters referred to in Note 16 of Notes to Consolidated Financial Statements, in particular the litigation filed by the City Attorney for Los Angeles on behalf of the State of California, the multi-state market conduct examination of our insurance subsidiaries led by the states of Washington and Alaska, the litigation filed by the Massachusetts Attorney General on behalf of the Commonwealth of Massachusetts and the market conduct examination of our insurance subsidiaries by the Massachusetts Division of Insurance, and the subsequent settlements of the multi-state market conduct examination and Massachusetts matters, generated significantly adverse publicity for the Company. Matters of this nature in the future could result in the loss of reputation and business for the Company and could have a material adverse effect on our financial condition and results of operations.

Our failure to secure and enhance cost-effective healthcare provider network contracts may result in a loss of insureds and/or higher medical costs and could have a material adverse effect on our financial condition and 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, the inability to maintain rental access to health care provider networks, or the refusal of health care providers to honor the discounts obtained through such networks, 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 have a material adverse effect on our financial condition and 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 investments in 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 through the payment of dividends. 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.

Failure to accommodate redemption requests by agents participating in the HealthMarkets, Inc. InVest Stock Ownership Plan could result in dissatisfaction and attrition among our contracted independent agents.

Historically, we have generally accommodated requests to purchase Class A-2 shares upon the withdrawal of a participant from the HealthMarkets, Inc. InVest Stock Ownership Plan, but we are under no obligation to do so. Any repurchase of shares requires the Company s consent, which may be withheld in our sole discretion. The ability to accommodate redemption requests is subject to a variety of factors, including the number of requests received and the Company s capital position. The volume of redemption requests generally has been low. If the number of redemption requests increases as a result of an event that is perceived by agents to have a negative

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effect on the Company s financial condition or operations (*e.g.* adverse publicity regarding the health insurance industry in general or our business specifically), the number of redemption requests could increase and the Company may elect not to accommodate such requests, which could result in dissatisfaction and substantial attrition among the agents within the Insphere distribution force as well as litigation risk.

Unfavorable economic conditions could adversely affect our business.

General economic, financial market and political conditions could have a material adverse effect on our financial condition and results of operations. Concerns over inflation, energy costs, geopolitical issues, the availability and cost of credit, the global mortgage market, a declining global real estate market, high unemployment, and the loss of consumer confidence and a reduction in consumer spending have contributed to increased volatility and diminished expectations for the economy and the markets going forward. These market conditions expose us to a number of risks, including risks associated with the potential financial instability of our customers. If our customer base experiences cash flow problems and other financial difficulties, it could, in turn, adversely impact the sale of the Company s insurance products and Insphere s distribution of third party products. For example, customers may modify, delay or cancel plans to purchase products, or may choose to reduce their level of coverage. In addition, if our customers experience financial difficulties, they may not be able to pay, or may delay payment of, premiums owed for insurance products. Further, our customers or potential customers may force us to compete more vigorously on factors such as price and service to retain or obtain their business. A significant decline in the sale of our products and the inability of current and/or potential customers to pay their premiums as a result of unfavorable economic conditions may adversely affect our business, including our revenues, profitability and cash flow. In addition, general inflationary pressures may affect the costs of health care, increasing the costs of paying claims.

In addition, we are subject to extensive laws and regulations that are administered and enforced by a number of different governmental authorities, including, but not limited to, state insurance regulators, the U.S. Securities and Exchange Commission and state attorneys general. In light of the difficult economic conditions, some of these authorities have adopted, or are considering the adoption of enhanced or new regulatory requirements intended to prevent future crises or to otherwise assure the stability of institutions under their supervision. These authorities may also seek to exercise their supervisory or enforcement authority in new or more robust ways. All of these possibilities, if they occurred, could affect the way we conduct our business and manage our capital, either of which in turn could have a material adverse effect on our financial condition and results of operations.

The value of our investments is influenced by varying economic and market conditions and a decrease in value could have an adverse effect on our financial condition and results of operations and liquidity.

Our investment portfolio is comprised of short term investments and investments classified as securities available for sale. The fair value of our investment portfolio was $1.1 billion and represented approximately 62.9% of our total consolidated assets at December 31, 2011. Available for sale securities are carried at fair value, and the unrealized gains or losses are included in accumulated other comprehensive loss as a separate component of shareholders equity, unless the decline in value is deemed to be other than temporary. For our available for sale investments, if a decline in value is deemed to be other than temporary, the security is deemed to be other than temporarily impaired (OTTI) and it is written down to fair value. OTTI losses attributed to credit loss are recorded in earnings while OTTI losses attributed to other factors are recorded in Accumulated other comprehensive income (loss) and have no effect on earnings. In accordance with applicable accounting standards, we review our investment securities to determine if declines in fair value below cost are other than temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis (or more frequently if certain indicators arise), using both quantitative and qualitative factors, to determine whether a decline in value is other than temporary. In its review, management 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;

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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.

The economic environment and potential volatility of the securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. During the years ended December 31, 2011 and 2010, we recorded $0 and $765,000, respectively, in charges for other than temporary impairment of securities. Given the potential for volatile market conditions and the significant judgments involved, there is continuing risk that material declines in fair value may occur and material other than temporary impairments may result in realized losses in future periods which could have a material adverse effect on our financial condition and results of operations.

Adverse securities and credit market conditions could have a material adverse affect on our liquidity or our ability to obtain credit on acceptable terms.

The securities and credit markets from time to time have experienced extreme volatility and disruption. In some cases, the markets have exerted downward pressure on the availability of liquidity and credit capacity for certain issuers. We need liquidity to make payments for benefits, claims and commissions and pay operating expenses. Our primary sources of cash on a consolidated basis have been premium revenue from policies issued, investment income, third-party commission revenue, and fees and other income. In the event we need access to additional capital to pay our operating expenses, pay capital expenditures or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant. Our access to additional financing will depend on a variety of factors such as market conditions, the general availability of credit, the overall availability of credit to our industry, our credit ratings and credit capacity, as well as the possibility that customers or lenders could develop a negative perception of our long- or short-term financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and, in such case, we may not be able to successfully obtain additional financing on favorable terms.

Failure of our insurance subsidiaries to maintain their current insurance ratings could have a material adverse effect on our financial condition and results of operations.

Our principal insurance subsidiaries are currently rated by A.M. Best. These ratings are subject to periodic review by the ratings agencies and there can be no assurances that we will be able to maintain these current ratings. A downward adjustment in rating by A.M. Best of our insurance subsidiaries could have a material adverse effect on our financial condition and results of operations. If our ratings are lowered from their current levels, our competitive position could be materially adversely affected and it could be more difficult for us to market our products. Rating agencies may take action to lower our ratings in the future due to, among other things, perceived concerns about our liquidity or solvency, the competitive environment in the insurance industry, which may adversely affect our revenues, the inherent uncertainty in determining reserves for future claims, which may cause us to increase our reserves for claims, the outcome of pending litigation and regulatory investigations, which may adversely affect our financial position and reputation and possible changes in the methodology or criteria applied by the rating agencies. In addition, rating agencies have come under recent scrutiny over their ratings practices and could, as a result, become more conservative in their methodology and criteria, which could adversely affect our ratings. Finally, rating agencies or regulators could increase capital requirements for the Company or its subsidiaries which in turn, could negatively affect our financial position as well. In light of the Company s decision to discontinue marketing its own health benefit plans in all but a limited number of states in which Insphere does not currently have access to third-party insurance products, the Company believes that the importance of the A.M. Best rating, as compared to previous periods when the Company widely marketed its own health benefits plans, has significantly diminished.

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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. New business opportunities may also require increased levels of statutory capital and surplus. 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.

Failure to accurately estimate medical claims and healthcare costs may have a significant impact on our financial condition and results of operations.

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 six-month or 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.

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. The Company s estimates with respect to claims liability and related benefit expenses are subject to an extensive degree of judgment and we cannot be certain 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 results of operations.

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

Current and future litigation with private parties or governmental authorities 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 establish 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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Given the expense and inherent risks and uncertainties of litigation, we regularly evaluate litigation matters pending against us, including those described in Note 16 of Notes to Consolidated Financial Statements, to determine if settlement of such matters would be in the best interests of the Company and its stockholders. The costs associated with any such settlement could be substantial and, in certain cases, could result in an earnings charge in any particular quarter in which we enter into a settlement agreement. Although we have recorded litigation reserves which represent our best estimate on probable losses, our recorded reserves might prove to be inadequate to cover an adverse result or settlement for extraordinary matters. Therefore, costs associated with the various litigation matters to which we are subject and any earnings charge recorded in connection with a settlement agreement could 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.

Acquisitions, divestitures and other significant transactions may adversely affect our business.

We continue to evaluate the profitability of our existing businesses and operations. From time to time, we review potential acquisitions and divestitures in light of our core businesses and growth strategies. The success of any such acquisition or divestiture depends, in part, upon our ability to identify suitable buyers or sellers, negotiate favorable contract terms and, in many cases, obtain governmental approval. For acquisitions, success is also dependent upon efficiently integrating the acquired business into the Company s existing operations. For divestures, in the event the structure of the transaction results in continuing obligations by the buyer to us or our customers, a buyer s inability to fulfill these obligations could lead to future financial loss on our part. In addition, any divestiture could result in significant asset impairment charges, including those related to goodwill and other intangible assets. In addition, potential acquisitions or divestitures present financial, managerial and operational challenges, including diversion of management attention from existing businesses, difficulty with integrating or separating personnel and financial and other systems, increased expenses, assumption of unknown liabilities, indemnities and potential disputes with the buyers or sellers.

Insphere Insurance Solutions is a relatively new business and its long-term success is uncertain.

The Company formed Insphere Insurance Solutions, Inc. in the second quarter of 2009 to serve as an insurance agency specializing in sales to small and middle-income markets. Insphere distributes life, health, long-term care and retirement insurance to these markets. The success of this new line of business depends on a number of factors, including, but not limited to, the ability of Insphere to maintain applicable licenses, recruit and retain productive agents, maintain and expand satisfactory relationships with insurance carriers and the implementation and maintenance of various information technology and administrative systems, platforms and processes necessary to successfully run the business. Like any business in a relatively early stage of development, the progress and success of Insphere entails substantial uncertainty. If the Company s attempt to develop the Insphere business does not progress as planned, the Company may be materially and adversely affected by, among other things, capital, investments, and operating expenses that have not led to the anticipated results.

A rapid reduction in the size of our in-force block of health benefits plans could result in a reduction in premium revenue and underwriting profits, which might not be replaced fully by premium revenue and underwriting profits associated with our supplemental insurance product offerings and commission revenue generated from Insphere distribution, and cause the Company to impair its goodwill and intangible assets.

In 2010, the Company discontinued the sale of its scheduled benefit health insurance products and discontinued marketing all health benefit plans underwritten by its insurance subsidiaries, in all but a limited number of states in which Insphere does not have access to third-party health insurance products. These actions reflect a number of factors, including (1) the Company s evaluation of National Health Care Reform Legislation which, among other things, requires a minimum medical loss ratio of 80% for the individual and small group markets beginning in 2011 and eliminates most annual caps on benefits - an important feature of our scheduled benefit products; (2) the Company s decision to focus on business opportunities that allow us to maximize the

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value of the Insphere independent agent sales force, with particular focus on the sale of third-party health insurance products underwritten by non-affiliated insurance companies and supplemental insurance products underwritten by the Company s insurance subsidiaries (which are generally not subject to the requirements of the Health Care Reform Legislation); and (3) the fact that in the states where third party health insurance plans distributed by Insphere have been introduced, they have, to a great extent, replaced the sale of the Company s own health benefit plan offerings.

The Company continues to maintain a significant in-force block of health benefit plans, and to underwrite and distribute its own health benefit plans in a limited number of states. We expect that maintenance of the Company s in-force block of health benefit plans, at current levels, will present significant challenges resulting from, among other things, competitive pressure due to the shift in our distribution focus toward third-party product sales, and changes resulting from Health Care Reform Legislation. For non-grandfathered plans, these changes include, but are not limited to, the obligation to add mandated essential benefits , which is expected to significantly increase costs; limitations on the ability to vary premium based on assessment of underlying risk (including elimination of pre-existing condition exclusions and health status rating adjustments); and the creation of health insurance exchanges with standardized plans and potential guarantee issue of coverage for the individual and small group markets, which may be an attractive option for our existing customers and cause them to cancel their coverage with us. The Company evaluates on an ongoing basis the impact of the Health Care Reform Legislation on its in-force block of health benefit plans.

We expect the size of our in-force block of health benefit plans to diminish over time and, as a result, we anticipate declines in premium revenue and underwriting profits associated with our in-force block. We do not expect these earnings to be replaced fully by premium revenue and underwriting profits associated with our supplemental insurance product offerings, or by commission revenue generated from Insphere distribution, which will make it difficult to support administrative expenses at current levels. To better align expenses in light of dropping enrollment levels, the Company has been pursuing initiatives to significantly reduce administrative expenses, including but not limited to reductions in its workforce, consolidation of certain administrative functions and the reorganization of Insphere s field structure to make it more efficient, and we expect initiatives of this nature to continue in the future. However, if developments occur that accelerate the reduction of our in-force block, including concerted efforts by agents to replace this business or a decision by the Company to non-renew its existing health benefit plan business in one or more states subject to applicable state and federal requirements, we may be unable to reduce expenses in a manner that keeps pace with dropping enrollment levels, which could have a material adverse effect on our financial condition and results of operations. Additionally, any adverse impact could cause the Company to impair its goodwill and intangible assets.

Insphere faces risks related to its relationships with non-affiliated insurance carriers.

Insphere contracts with non-affiliated carriers to distribute products underwritten by such carriers. These contracts generally provide that either party may terminate the contract for convenience by providing the other party with a relatively short period of advance notice. In any particular market, carriers could terminate their contracts with us (or refuse to contract with us), demand lower commissions or take other actions, including litigation, which could adversely affect our business. We are also dependent on non-affiliated carriers to pay Insphere in a timely and accurate manner and to provide Insphere with data required to support the sale of third party products and to timely and accurately pay its agents. The failure by a non-affiliated carrier to provide Insphere with the data and support necessary for Insphere to sell the carrier s products and to pay its agents, resulting from a failure in data systems or otherwise, could materially and adversely affect Insphere s business. Our business is also vulnerable to a non-affiliated carrier s failure to administer underwritten business in an appropriate manner, which could lead to customer dissatisfaction and the lapse or cancellation of insurance policies for which Insphere receives commissions. Insphere could also be materially and adversely affected if a non-affiliated carrier with which it does business experiences a downgrade in its financial strength ratings which, for the affected carrier, could reduce Insphere s level of business and commissions.

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A failure of our information systems to provide timely and accurate information could have a material adverse effect on our financial condition 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 have a material adverse effect on our financial condition 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.

Our reliance on outsourcing arrangements subjects us to risk and may disrupt or adversely affect our operations.

Historically, we have maintained an administrative center with underwriting, claims management and administrative capabilities performed in-house. Over the last several years, we have outsourced many of these functions, including new business processing, provider service calls and a larger portion of the claims processing functions, to contracted third parties, including parties who may perform these functions offshore. We evaluate opportunities to subcontract additional services of this nature on an ongoing basis and may outsource additional functions in the future. The Company retains ultimate responsibility for ensuring that these functions are performed in a timely and appropriate manner. Dependence on third parties for these services may make our operations vulnerable to the third party s failure to perform as agreed. If these third parties fail to satisfy their obligations to us, including obligations with respect to the security and confidentiality of information and data of the Company and/or its customers, our operations may be adversely affected. Reliance on third parties also makes us vulnerable to changes in the vendors business, financial condition and other matters outside of our control. The failure to adequately monitor and regulate the performance of our third party vendors could subject us to additional risk. Violations of laws or regulations by third party vendors could increase our exposure to liability or otherwise increase the costs associated with the operation of our business. Some of our outsourced services are being performed offshore, which could expose us to risks inherent in conducting business outside of the United States, including international economic and political conditions and additional costs associated with complying with foreign laws. If an outsourced relationship is terminated, we may not be able to find a replacement in a timely manner or on acceptable financial terms, and may incur significant costs in connection with the transition to a new vendor.

Natural disasters could severely damage or interrupt our systems and operations and result in an adverse effect on our business.

Natural disasters such as fire, flood, earthquake, tornado, power loss, virus, telecommunications failure, break-in or similar event could severely damage or interrupt our systems and operations, result in loss of data, and/or delay or impair our ability to service our customers. We have in place a disaster recovery plan which is intended to provide us with the ability to maintain our operations in the event of a natural disaster. However, there can be no assurance that such adverse effects will not occur in the event of a disaster. Any such disaster or similar event could have a material adverse effect on our financial condition and results of operations.

If we are unable to retain key executives or appropriately manage succession, our business could be adversely affected.

We have experienced high turnover in our senior management team in recent years. Although we have employment arrangements in place with our key executives, these do no guarantee that the services of these executives will continue to be available to us, and we would be adversely affected if we fail to adequately plan for future turnover of our senior management team.

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Item 1B. ***Unresolved Staff Comments***
None

Item 2. ***Properties***
We currently own our executive offices located at 9151 Boulevard 26, North Richland Hills, Texas 76180-5605 comprising in the aggregate approximately 281,000 square feet of office space.

In addition, we lease office space at various locations in 36 states for our Insphere agent field offices comprising in the aggregate approximately 214,000 square feet.

Item 3. ***Legal Proceedings***
See Note 16 of Notes to Consolidated Financial Statements, the terms of which are incorporated by reference herein.

Item 4. ***Reserved***
None

PART II

Item 5. ***Market for Registrant s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities***
Shares of the Company s Class A-1 and Class A-2 common stock are not listed for trading on the New York Stock Exchange or any other exchange and are not readily tradable or salable in any public market. As of February 29, 2012, there were approximately 87 holders of record of Class A-1 common stock and 939 holders of record of Class A-2 common stock.

Effective February 25, 2010, the Board of Directors of HealthMarkets, Inc. declared a special dividend in the amount of $3.94 per share for Class A-1 and Class A-2 common stock to holders of record as of the close of business on March 1, 2010, payable on March 9, 2010. In connection with the special cash dividend, the Company issued dividends to stockholders in the aggregate amount of $119.5 million.

Set forth below is a summary of the Company s sale of shares of HealthMarkets, Inc. Class A-1 common stock during 2011, 2010, and 2009:

	2011		
	Shares Issued (shares)	Consideration Received ($)	Avg Per Share ($)
Sale of shares to Executive Officers	7,850	72,613	9.25
Sale to employee participants in the InVest Stock Ownership Plan	89,635	840,799	9.38
Issuance of unvested restricted shares to Company Officers			
	97,485	913,412	9.37

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	2010		
	Shares Issued (shares)	Consideration Received ($)	Avg Per Share ($)
Sale of shares to Executive Officers	76,140	558,868	7.34
Sale to employee participants in the InVest Stock Ownership Plan	190,955	1,888,782	9.89
Issuance of unvested restricted shares to Company Officers	686,547		
	953,642	2,447,650	2.57

	2009		
	Shares Issued (shares)	Consideration Received ($)	Avg Per Share ($)
Sale of shares to Executive Officers	5,263	99,997	19.00
Issuance of unvested restricted shares to Company Officers	836,502		
	841,765	99,997	0.12

Such sale of securities was 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 there under) for transactions by an issuer not involving a public offering. The proceeds of such sale were used for general corporate purposes.

Issuer Purchases of Equity Securities

Set forth below is a summary of the Company s purchases of shares of HealthMarkets, Inc. Class A-1 and A-2 common stock during each of the months in the twelve-month period ended December 31, 2011:

	Issuer Purchase of Equity Securities Class A-1			
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
01/1/11-01/31/11				
02/1/11-02/28/11				
03/1/11-03/31/11	81,130	9.25		
04/1/11-04/30/11	42	9.25		
05/1/11-05/31/11	58,949	9.35		
06/1/11-06/30/11	25,392	9.35		
07/1/11-07/31/11				
08/1/11-08/31/11	7,978	9.37		
09/1/11-09/30/11	2,645	9.37		
10/1/11-10/31/11	4,292	9.37		
11/1/11-11/30/11	206,920	9.58		
12/1/11-12/31/11	7,264	9.58		

Totals	394,612	9.46

(1) The number of shares purchased other than through a publicly announced plan or program includes 94,432 Class A-1 shares purchased from the ISOP and 300,180 Class A-1 shares purchased from current or former employees of the Company. These shares were reflected as treasury shares on the Company s Consolidated Balance Sheet at the time of purchase.

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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
01/1/11-01/31/11				
02/1/11-02/28/11				
03/1/11-03/31/11	201,170	9.25		
04/1/11-04/30/11	50,784	9.25		
05/1/11-05/31/11	87,498	9.35		
06/1/11-06/30/11	23,903	9.35		
07/1/11-07/31/11	23,211	9.35		
08/1/11-08/31/11	122,418	9.37		
09/1/11-09/30/11	25,438	9.37		
10/1/11-10/31/11	59,459	9.33		
11/1/11-11/30/11	73,603	9.58		
12/1/11-12/31/11	65,968	9.58		
Totals	733,452	9.37		

(1) The number of shares purchased other than through a publicly announced plan or program includes 708,317 Class A-2 shares purchased from ISOP and 25,135 Class A-2 shares purchased from former participants in the ISOP. These shares were reflected as treasury shares on the Company s Consolidated Balance Sheet at the time of the purchase.

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Item 6. ***Selected Financial Data***

The following selected consolidated financial data as of and for each of the five years in the year ended December 31, 2011 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.

	For the Year Ended December 31,				
	2011	2010	2009	2008	2007
	(In thousands, except per share amounts and operating ratios)				
Income Statement Data:					
Revenues from continuing operations	$ 665,197	$ 861,653	$ 1,083,397	$ 1,424,965	$ 1,595,509
Income (loss) from continuing operations before income taxes	18,710	82,027	29,238	(85,380)	119,053
Income (loss) from continuing operations	10,668	50,131	17,562	(53,671)	69,370
Income from discontinued operations	79	66	162	216	789
Net income (loss)	$ 10,747	$ 50,197	$ 17,724	$ (53,455)	$ 70,159
Per Share Data:					
Earnings (loss) per share from continuing operations:					
Basic earnings (loss) per share	$ 0.35	$ 1.69	$ 0.59	$ (1.78)	$ 2.28
Diluted earnings (loss) per share	$ 0.34	$ 1.64	$ 0.58	$ (1.78)	$ 2.21
Earnings per share from discontinued operations:					
Basic earnings per share	$ 0.00	$ 0.00	$ 0.01	$ 0.01	$ 0.03
Diluted earnings per share	$ 0.00	$ 0.00	$ 0.01	$ 0.01	$ 0.03
Earnings (loss) per share:					
Basic earnings (loss) per share	$ 0.35	$ 1.69	$ 0.60	$ (1.77)	$ 2.31
Diluted earnings (loss) per share	$ 0.34	$ 1.64	$ 0.59	$ (1.77)	$ 2.24
Operating Ratios:					
Health Ratios:					
Loss ratio	66%	50%	60%	65%	57%
Expense ratio	19	23	34	36	38
Combined health ratio	85%	73%	94%	101%	95%
Balance Sheet Data:					
Total investments, cash and cash equivalents	$ 1,071,913	$ 1,065,302	$ 1,155,247	$ 1,127,945	$ 1,495,910
Total assets	1,676,718	1,719,651	1,871,498	1,916,713	2,155,582
Total policy liabilities	629,596	704,997	856,528	973,046	1,001,406
Total debt (excluding student loan credit facility)	553,420	553,420	481,070	481,070	481,070
Long term leases	11,431	11,912	9,678	10,428	17,141
Student loan credit facility	60,050	68,650	77,350	86,050	97,400
Stockholders equity	273,822	235,128	262,199	197,925	306,260
Stockholders equity per share	$ 8.94	$ 7.58	$ 8.69	$ 6.68	$ 10.03
Cash dividends per share	$	$ 3.94	$	$	$ 10.51

Loss ratio. The loss ratio is defined as benefits, claims and settlement expenses as a percentage of earned premiums (excludes former Life Insurance Division).

Expense ratio. The expense ratio is defined as underwriting, acquisition and insurance expenses as a percentage of earned premiums (excludes former Life Insurance Division).

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

The following discussion should be read in conjunction with HealthMarkets consolidated financial statements and the related notes included elsewhere in this Form 10-K. This discussion contains certain statements which may be considered forward-looking. Actual results and the timing of events may differ significantly from those expressed or implied in such forward-looking statements due to a number of factors, including those set forth in the section entitled Risk Factors and elsewhere in this Form 10-K.

Additionally, the Company may also disclose financial information on a non-GAAP basis when management uses this information and believes this information will be valuable to investors in measuring the quality of our financial performance, identifying trends in our results and providing more meaningful period-to-period comparisons.

Business Summary

HealthMarkets, Inc., a Delaware corporation incorporated in 1984, is a holding company, the principal asset of which is its investment in its wholly owned subsidiary, HealthMarkets, LLC. HealthMarkets, LLC s principal assets are its investments in its separate operating subsidiaries, including its regulated insurance subsidiaries. HealthMarkets conducts its insurance underwriting businesses through its 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), and conducts its insurance distribution business through its indirect insurance agency subsidiary, Insphere Insurance Solutions, Inc. (Insphere)

Through our insurance subsidiaries, we issue primarily health insurance policies, covering individuals, families, the self-employed and small businesses, and supplemental products. MEGA is an insurance company domiciled in Oklahoma and is licensed to issue health, life and annuity insurance policies in the District of Columbia and 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, the District of Columbia, 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 the District of Columbia and all states except New Jersey, New York and Vermont.

The Company has recently experienced significant strategic changes, primarily in connection with the launch of its Insphere insurance agency in 2009 and the development of Insphere since that time. Insphere serves as an authorized insurance agency in 50 states and the District of Columbia, specializing in the distribution to the small business and middle-income market. Insphere distributes life, health, long-term care and retirement insurance through a portfolio of products from nationally recognized insurance carriers. As of December 31, 2011, Insphere had offices in 36 states with approximately 2,900 independent agents, of which approximately 1,800 agents on average write health insurance applications each month. Insphere distributes products underwritten by the Company s insurance subsidiaries, as well as non-affiliated insurance companies.

The Company is generally focused on business opportunities that allow us to maximize the value of the Insphere independent agent sales force, with particular focus on the sale of supplemental insurance products underwritten by the Company s insurance subsidiaries and third-party health insurance products underwritten by non-affiliated insurance companies. In 2010, we discontinued the sale of the Company s traditional scheduled benefit health insurance products and discontinued marketing all health benefit plans underwritten by our insurance subsidiaries in all but a limited number of states in which Insphere does not have access to third-party health insurance products. We believe that this shift better positions the Company for the future, particularly in light of changes resulting from the enactment, in March 2010, of the Patient Protection and Affordable Care Act and a reconciliation measure, the Health Care and Education Reconciliation Act of 2010 (collectively, the Health Care Reform Legislation). The Company continues to maintain a significant in-force block of health benefits plans and evaluates on an ongoing basis the impact of Health Care Reform Legislation on this block.

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The Company operates four business segments: the Commercial Health Division, Insphere, Corporate and Disposed Operations. Through our Commercial Health Division, we underwrite and administer a broad range of health and supplemental insurance products. Insphere includes net commission revenue, agent incentives, marketing costs and costs associated with the creation and development of Insphere. Corporate includes investment income not allocated to the other segments, realized gains or losses, interest expense on corporate debt, the Company s student loan business, general expenses relating to corporate operations and operations that do not constitute reportable operating segments. Disposed Operations includes the remaining run out of the Medicare Division and the Other Insurance Division, as well as the residual operations from the disposition of other businesses prior to 2009. (See Note 19 of Notes to Consolidated Financial Statements for financial information regarding our segments).

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:

	For the Year Ended December 31,		
	2011	2010	2009
		(In thousands)	
Revenue:			
Health premiums	$ 543,092	$ 735,538	$ 977,568
Life premiums and other considerations	1,565	1,913	2,381
	544,657	737,451	979,949
Investment income	28,028	42,246	43,166
Commissions and other income	83,570	76,906	62,401
Net impairment losses recognized in earnings		(765)	(4,504)
Realized gains, net	8,942	5,815	2,385
Total revenues	665,197	861,653	1,083,397
Benefits and Expenses:			
Benefits, claims, and settlement expenses	359,424	366,644	584,878
Underwriting, acquisition and insurance expenses	101,441	173,830	338,028
Other expenses	163,540	209,070	98,821
Interest expense	22,082	30,082	32,432
Total benefits and expenses	646,487	779,626	1,054,159
Income from continuing operations before income taxes	18,710	82,027	29,238
Federal income tax expense	8,042	31,896	11,676
Income from continuing operations	10,668	50,131	17,562
Income from discontinued operations (net of income tax)	79	66	162
Net income	$ 10,747	$ 50,197	$ 17,724

Revenue

The majority of our 2011 revenue was earned on health premiums derived from our inforce block of our indemnity and preferred provider organization (PPO) policies in our Commercial Health Division. Premiums on health insurance contracts are recognized as earned over the period of coverage on a pro rata basis. We also earned revenue on premiums from traditional life insurance polices, which are recognized as revenue when due. The decrease in premium reflects the change in the Company s strategic focus, in connection with the launch of Insphere, on selling products underwritten by third-party carriers. The Company currently markets its health benefit plans in only a limited number of states in which Insphere does not have access to third-party health insurance products. The Company continues to offer supplemental insurance products underwritten by the Company s insurance subsidiaries.

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Effective in 2011, if the medical loss ratios of our fully insured health products(calculated in accordance with the Health Care Reform Legislation and implementing regulations) fall below certain targets, our insurance subsidiaries will be required to rebate ratable portions of their premiums annually. Rebate payments for 2011 are to be paid by August 1, 2012. As a result, the decrease in earned premium also reflects the recording of an accrual for the estimated medical loss ratio rebate. At December 31, 2011, the Company has accrued $26.9 million for this medical loss ratio rebate.

Investment income includes investment income derived from our investment portfolio and interest received on student loans.

Commission and other income consists primarily of commission and bonus revenue generated from the sale of third-party insurance products, association memberships and ancillary services.

Benefits and Underwriting, Acquisition and Insurance Expenses

These expenses consist primarily of insurance claim expense and expenses associated with the underwriting and acquisition of insurance policies underwritten by the Company s insurance subsidiaries. Claims expense consists primarily of payments to physicians, hospitals and other healthcare providers under health policies, and includes an estimated amount for incurred but not reported and unpaid claims. Underwriting, acquisition and insurance expenses consist of marketing and 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. Benefits and underwriting, acquisition and insurance expenses have continued to decrease in tandem with the decrease in premiums. Additionally, beginning in 2008, the Company initiated certain general and administrative cost reduction programs. These cost reduction efforts are still ongoing. Beginning in 2010, the Company s focus has been on selling third-party products rather the health benefit plans underwritten by its own insurance companies. As a result, the majority of our marketing costs have been incurred by Insphere. These marketing costs incurred by Insphere are recorded on the Company s consolidated statements of operations in Other Expenses.

Other Expenses

Other Expenses consists of costs incurred with our Insphere operations, general expenses relating to corporate operations and direct expenses incurred in connection with generating income from ancillary services and marketing services provided to the membership associations with which we maintain contracts. The Insphere expenses include agent compensation for the sale of third-party products, other agent incentives, employee compensation, lead costs, costs associated with our field offices and other expenses related to the continuing development of Insphere. Other expenses also include expenses incurred with the Company-matching feature of the Invest Stock Ownership Plan.

Business Segments

The following is a comparative discussion of results of operations for our business segments and divisions. Allocations of investment income and certain general expenses are based on a number of assumptions and estimates, and the reported operating results for our business segments would change if different allocation methods were applied. Certain assets are not individually identifiable by segment and, accordingly, have been allocated by formulas. Segment revenues include premiums and other policy charges and considerations, net investment income, commission revenue, fees and other income. Management does not allocate income taxes to segments. Transactions between reportable segments are accounted for under respective agreements, which provide for such transactions generally at cost.

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Revenue from continuing operations and income (loss) from continuing operations before federal income taxes (Operating income) for each of our business segments and divisions were as follows:

	For the Year Ended December 31,		
	2011	2010	2009
		(In thousands)	
Revenue from continuing operations:			
Commercial Health Division	$ 585,269	$ 798,666	$ 1,061,450
Insphere	73,723	46,170	1,192
Corporate	24,009	24,737	13,616
Intersegment Eliminations	(19,397)	(10,327)	(2,088)
Total revenues excluding disposed operations	663,604	859,246	1,074,170
Disposed Operations	1,593	2,407	9,227
Total revenue from continuing operations	$ 665,197	$ 861,653	$ 1,083,397

	For the Year Ended December 31,		
	2011	2010	2009
		(In thousands)	
Income (loss) from continuing operations before federal income taxes:			
Commercial Health Division	$ 101,928	$ 236,771	$ 117,498
Insphere	(53,694)	(81,335)	(11,902)
Corporate	(31,251)	(76,432)	(73,336)
Total operating income excluding disposed operations	16,983	79,004	32,260
Disposed Operations	1,727	3,023	(3,022)
Total income from continuing operations before federal income taxes	$ 18,710	$ 82,027	$ 29,238

Assets by operating segment at December 31, 2011, 2010, and 2009 are set forth in the table below:

	December 31,		
	2011	2010	2009
		(In thousands)	
Assets:			
Commercial Health Division	$ 404,033	$ 490,088	$ 731,594
Insphere	62,194	77,139	14,507
Corporate	830,253	769,105	734,040
Total assets excluding assets of Disposed Operations	1,296,480	1,336,332	1,480,141
Disposed Operations	380,238	383,319	391,357
Total assets	$ 1,676,718	$ 1,719,651	$ 1,871,498

Disposed Operations assets at December 31, 2011, 2010 and 2009 primarily represent reinsurance recoverable of $356.8 million, $356.7 million and $353.7 million, respectively, associated with the Company s former Life Insurance Division.

Commercial Health Division

Through our Commercial Health Division, we issued a broad range of health insurance products for individuals, families, the self-employed and small businesses. Our plans are designed to accommodate individual needs and include basic hospital-medical expense plans, plans with preferred provider organization features, catastrophic hospital expense plans, as well as other supplemental types of coverage. Prior to 2010 we marketed

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these products to the self-employed and individual markets through independent agents contracted with our insurance subsidiaries. Beginning in 2010, these products were primarily marketed through independent agents contracted with Insphere.

Set forth below is certain summary financial and operating data for the Commercial Health Division for each of the three most recent fiscal years:

	For the Year Ended December 31,		
	2011	2010	2009
	(Dollars in thousands)		
Revenues:			
Earned premium revenue	$ 544,661	$ 736,809	$ 973,331
Investment income	13,999	21,579	26,427
Commission and other income	26,609	40,278	61,692
Total revenues	585,269	798,666	1,061,450
Expenses:			
Benefits, claims and settlement expenses	360,087	369,764	578,361
Underwriting, acquisition and insurance expenses	115,747	177,924	331,437
Other expenses	7,507	14,207	34,154
Total expenses	483,341	561,895	943,952
Operating income	$ 101,928	$ 236,771	$ 117,498
Other operating data:			
Loss ratio	66.1%	50.2%	59.4%
Expense ratio	21.3%	24.1%	34.1%
Combined health ratio	87.4%	74.3%	93.5%
Operating margin	18.7%	32.1%	12.1%
Submitted annualized volume	$ 58,910	$ 59,008	$ 321,918

Loss Ratio. The loss ratio is defined as benefits expense as a percentage of earned premium revenue.

Expense Ratio. The expense ratio is defined as underwriting, acquisition and insurance expenses as a percentage of earned premium revenue.

Operating Margin. Operating margin is defined as operating income as a percentage of earned premium revenue.

Submitted Annualized Volume. 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.

Year Ended December 31, 2011 versus December 31, 2010

The Commercial Health Division reported earned premium revenue of $544.7 million in 2011 compared to $736.8 million in 2010, a decrease of $192.1 million or 26.1%, which is primarily due to a decrease in policies in force. Total policies in force decreased by 21.5% to approximately 117,000 during 2011 as compared to approximately 149,000 during 2010. The decrease in policies in force is primarily due to the Company s decision to discontinue the marketing of its health benefit plans in all but a limited number of states in which Insphere does not currently have access to third-party health insurance products. The Company continues to offer its supplemental products underwritten by Chesapeake and is focused on growing this line of business. However, the premium generated by the supplemental business has not been enough to offset the decline in premium associated with the Company s health benefit plans. The decrease in premium in 2011 also reflects the accrual of $26.9 million for the medical loss ratio rebate.

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The Commercial Health Division reported operating income of $101.9 million in 2011 compared to operating income of $236.8 million in 2010, a decrease of $134.9 million or 57.0%. The decrease in operating income during the current year period is generally attributable to an increase in the loss ratio as discussed more fully below, partially offset by a reduction in underwriting acquisition and insurance expenses.

During 2011 and 2010, the Company updated its loss reserve analysis to reflect more recent patterns of paid claims. The impact on the operating margin as a result of the update of its loss reserve analysis was larger in 2010 than in 2011. The 2010 favorable impact was $40.8 million compared to the favorable impact of $7.8 million for 2011. Additionally, the 2010 claim development also reflects the Company s refinement of a previously estimated claim liability, established in the fourth quarter of 2009, arising from a review of claim processing for state mandated benefits. As a result of this refinement, during 2010, the Company recognized a decrease in claim liabilities of $19.6 million.

Underwriting, acquisition and insurance expense decreased by $62.2 million, or 35.0% to $115.7 million in 2011 from $177.9 million in 2010. This decrease reflects the variable nature of commission expenses and premium taxes included in these amounts which generally vary in proportion to earned premium revenue. Additionally, the Company continues to decrease its administrative costs, which are being reflected as a decrease in the expense ratio. Other factors contributing to the decrease in underwriting, acquisition and insurance expenses include a decrease in the overall effective commission rate as a result of the decrease in new business. Generally, first year commission rates paid to agents are higher than renewal year commission rates. Additionally, with the formation of Insphere and the sale of third-party health insurance products underwritten by non-affiliated insurance carriers, the Commercial Health Division has significantly decreased the amount of marketing and acquisition costs.

Commission and other income and Other expenses both decreased in the current period compared to the prior year period. Commission and other income largely consists of fee and other income received for sales of association memberships prior to the formation of Insphere, for which Other expenses are incurred for bonuses and other compensation provided to the agents. Association memberships are generally sold with a health insurance policy and as the number of health insurance policies decrease, the income and expense will generally decrease.

Year Ended December 31, 2010 versus December 31, 2009

The Commercial Health Division reported earned premium revenue of $736.8 million in 2010 compared to $973.3 million in 2009, a decrease of $236.5 million or 24%, which is due to a decrease in policies in force. Total policies in force decreased by 32% to approximately 149,000 during 2010 as compared to approximately 218,000 during 2009. The decrease in policies in force reflects an attrition rate that exceeds the pace of new sales, and is evident in the reduction in submitted annualized premium volume from $321.9 million in 2009 to $59.0 million in 2010. The decrease in policies in force is due in large part to the Company s decision to discontinue the marketing of its health benefit plans in all but a limited number of states in which Insphere does not currently have access to third-party health insurance products.

The Commercial Health Division reported operating income of $236.8 million in 2010 compared to operating income of $117.5 million in 2009, an increase of $119.3 million or 102%. The increase in operating income during the current year period is generally attributable to a loss ratio reflecting better claims experience and a reduction in underwriting acquisition and insurance expenses.

The favorable claims development reflects an update to the completion factors used at the end of the third quarter of 2010 to reflect more recent patterns of claim payments. The favorable impact of the updated completion factors was $30.6 million. The favorable claim development also reflects the Company s refinement of a previously estimated claim liability, established in the fourth quarter of 2009, arising from a review of claim processing for state mandated benefits. As a result of this refinement, during 2010, the Company recognized a decrease in claim liabilities of $19.6 million. In the fourth quarter of 2010, the Company made additional refinements to its claim reserving process which reduced the claim reserve by approximately $10.2 million.

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Underwriting, acquisition and insurance expense decreased by $153.5 million, or 46% to $177.9 million in 2010 from $331.4 million in 2009. This decrease reflects the variable nature of commission expenses and premium taxes included in these amounts which generally vary in proportion to earned premium revenue and, in addition certain cost reduction programs initiated in the fourth quarter of 2008, which are being reflected as a decrease in the expense ratio. Other factors contributing to the decrease in underwriting, acquisition and insurance expenses include a decrease in the overall effective commission rate as a result of the decrease in new business. Generally, first year commission rates paid to agents are higher than renewal year commission rates. Additionally, with the formation of Insphere and the sale of third-party health insurance products underwritten by non-affiliated insurance carriers, the Commercial Health Division has significantly decreased the amount of marketing and acquisition costs.

Other income and other expenses both decreased in the current period compared to the prior year period. Other income largely consists of fee and other income received for sales of association memberships prior to the formation of Insphere, for which other expenses are incurred for bonuses and other compensation provided to the agents. Association memberships are generally sold with a health insurance policy and as the number of health insurance policies decrease, other income and other expense will generally decrease.

Insphere

During the second quarter of 2009, we formed Insphere, an authorized insurance agency in 50 states and the District of Columbia specializing in small business and middle-income market life, health, long-term care and retirement insurance. Insphere distributes products underwritten by our insurance subsidiaries, as well as non-affiliated insurance companies.

Set forth below is certain summary financial and operating data for Insphere for the twelve months ended December 31, for each of the three most recent years:

	For the Year Ended December 31,		
	2011	2010	2009
	(Dollars in thousands)		
Revenue:			
Commission revenue from non-affiliates	$ 44,293	$ 35,136	$ 1,137
Commission revenue from affiliates	15,154	4,917	
Commission revenue from association memberships	12,112	4,498	
Investment income	1,024	442	
Other income	1,140	1,177	55
Total revenue	73,723	46,170	1,192
Expenses:			
Commission expenses	39,127	22,410	459
Agent incentives and leads	27,513	37,322	3,568
Other expenses	60,777	67,773	9,067
Total expenses	127,417	127,505	13,094
Operating loss	$ (53,694)	$ (81,335)	$ (11,902)

Insphere generates revenue primarily from base commissions and override commissions received from insurance carriers whose policies are purchased through Insphere s independent agents. The commissions are typically based on a percentage of the premiums paid by the insured to the carrier. In some instances, Insphere also receives bonus payments for achieving certain sales volume thresholds. Insphere typically receives commission payments on a monthly basis for as long as a policy remains active. As a result, much of our revenue for a given financial reporting period relates to policies sold prior to the beginning of the period and is recurring in nature. Commission rates are dependent on a number of factors, including the type of insurance product and the particular insurance company underwriting the policy.

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The Company continues to evaluate new distribution opportunities and continues efforts to expand its portfolio and the size of its field force by developing additional marketing arrangements. We believe the implementation of these new opportunities, along with the current cost reduction program, will help mitigate future operating losses.

Year Ended December 31, 2011 versus December 31, 2010

For the years ended December 31, 2011 and 2010, the Company earned commission revenue of approximately $71.6 and $44.6 million, respectively. For 2011 and 2010, respectively, approximately 91% and 93% of commission revenue from non-affiliates was generated from four carriers.

Insphere did not begin writing business until the fourth quarter of 2009 and as a result the revenue for the 2011 is significantly greater than the comparable period in 2010. Partially offsetting Insphere s revenue growth in sales in 2011 is the impact of certain elements of Health Care Reform. Beginning in 2011, in response to Health Care Reform, both the Company s insurance subsidiaries and certain third-party carriers decreased the level of commissions paid to Insphere. Commission revenue for 2010 also reflects certain one-time payments from third-party carriers for achieving certain production thresholds and consideration for contract renegotiation fees. The results for 2011 do not reflect similar amounts of these one-time payments.

Commission expense includes commissions and overrides paid to our independent agents. Commissions are generally based on a percentage of the premiums paid by the insured to the carrier. The increase in commission expense from $22.4 million incurred during the twelve months ended December 31, 2010 to $39.1 million incurred during the twelve months ended December 31, 2011, primarily trends with commission revenue. However, beginning in the third quarter of 2010, Insphere increased its commission rates paid to its agents to incorporate some of the costs previously included in Agent incentives.

Agent incentives primarily include production and agent recruiting bonuses paid to our independent agents as well as lead generation costs incurred to facilitate the production of commission revenue. The decrease in Agent incentives as a percentage of Commission revenue from the prior year reflects the adjustment to commission rates to incorporate some of these costs as discussed above. In addition, beginning in the last half of 2010, the agents started sharing some of the costs of purchasing customer leads which reduced some of the lead generation costs for the Company.

Other expenses associated with Insphere are related to employee compensation, costs associated with our field offices, depreciation and amortization, and other administrative expenses. Other expenses also reflect the significant amount of development to build-out technology to support multiple carriers and enhance the Insphere distribution channel by equipping our agents with efficient technology to cross-sell products. Other expenses have decreased from prior year as a result of both cost cutting initiatives and a reduction in costs associated with the development of Insphere.

During the second and third quarters of 2010 the Company made the decision to wind down its broker-dealer operations, Insphere Securities, Inc. and to consolidate some of its agent sales offices, as a result of which it closed various leased facilities. During 2010, Insphere recorded lease impairment charges in the amount of $1.3 million and other wind down costs of $1.7 million. The wind-down charges incurred by Insphere Securities, Inc. related to employee termination costs, write-down of fixed assets and intangible assets and operations termination costs. These charges are reflected in Other expenses in the table above.

Year Ended December 31, 2009

Insphere was formed during the second quarter of 2009, and as a result Insphere reported an operating loss of $11.9 million comprised primarily of start up costs incurred with the creation and development of Insphere.

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Corporate

Corporate includes investment income not otherwise allocated to the other segments, realized gains and losses on sales, interest expense on corporate debt, the Company s Student Loan business, general expense relating to corporate operations and operations that do not constitute reportable operating segments.

Set forth below is a summary of the components of operating income (loss) at Corporate for each of the three most recent fiscal years:

	For the Year Ended December 31,		
	2011	2010	2009
		(In thousands)	
Operating income (loss):			
Investment income	$9,317	$15,358	$10,519
Net investment impairment losses recognized in earnings		(765)	(4,504)
Realized gains, net	8,942	5,815	2,385
Interest expense on corporate debt	(22,080)	(30,081)	(31,566)
Student loan operations	(174)	(324)	(14)
Variable stock-based compensation (expense) benefit	(619)	1,682	(858)
General corporate expenses and other	(26,637)	(68,117)	(49,298)
Operating loss	$(31,251)	$(76,432)	$(73,336)

Year Ended December 31, 2011 versus December 31, 2010

Corporate continues to report operating losses primarily as a result of the decreased earnings on its investment portfolio not exceeding the debt service costs and other general corporate expenses. The changes for the period are primarily due to the following items:

Investment income decreased by $6.0 million due to a decrease in the amount of assets invested in higher yielding fixed maturities. As fixed maturities in the bond portfolio are sold or mature, the Company has been reinvesting these in short-term investments in preparation to repay its $362.5 million term loan.

Realized gains, net increased by $3.1 million over prior year. The increase in realized gains during 2011 is the result of the sale of various fixed maturities to increase liquidity to repay the Company s term loan which matures in 2012. The Company repaid this debt in full on February 29, 2012.

Net investment impairment losses recognized in earnings decreased by $765,000 as we recognized no impairment losses on other-than-temporary impairments in 2011 as compared to one impairment loss recorded in 2010 on one security. The impairment charges in 2010 resulted from other than temporary reductions in the fair value of these investments compared to our cost basis (see Note 4 of Notes to Consolidated Financial Statements for additional information).

Interest expense on corporate debt decreased by $8.0 million in 2011 compared to 2010, primarily due to the lower interest rate environment experienced in 2011 and the maturity of the remaining interest rate swap in April 2011.

We maintain, for the benefit of our independent agents and certain designated employees, a stock-based compensation plan the HealthMarkets, Inc. InVest Stock Ownership Plan (the ISOP). In connection with this plan, we record a non-cash variable stock-based compensation benefit or expense based on the performance of the fair value of our common stock. Variable stock-based compensation expense increased by $2.3 million primarily as a result of the increase in share price during 2011.

General corporate expenses and other decreased by $41.5 million from the prior year. The 2010 results include approximately $37.4 million of additional salary expense and stock compensation compared to the 2011. These charges are primarily related to reductions in the Company s work force and the previously announced changes to the Company s executive management team during 2010.

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Year Ended December 31, 2010 versus December 31, 2009

Corporate reported an operating loss in 2010 of $76.4 million compared to $73.3 million in 2009 for a small increase in operating expenses of $3.1 million. The changes for the period are primarily due to the following items:

Investment income increased by $4.8 million due to a reduction in the amount of investment income allocated to the Commercial Health Division in 2010 compared to 2009. Overall, investment income was comparable to prior year; however, the amount of investment income allocated to the Commercial Health Division was significantly lower than the prior year. The basis for the allocation was consistently applied for both years.

Realized gains, net increased by $3.4 million over prior year. During 2010 unrealized gains related to our portfolio increased and the Company sold a substantial portion of its municipal investments to reduce its exposure, which generated realized gains.

Net investment impairment losses recognized in earnings decreased by $3.7 million as we recognized impairment losses on other-than-temporary impairments of $765,000 in 2010 on one security, compared to $4.5 million on four securities during 2009. These impairment charges resulted from other than temporary reductions in the fair value of these investments compared to our cost basis.

Interest expense on corporate debt decreased by $1.5 million in 2010 compared to 2009, primarily due to the lower interest rate environment experienced in 2010 and the maturity of one of our interest rate swaps in April 2010. Partially offsetting these decreases, the 2010 results include $4.9 million of interest expense associated with our Grapevine Finance LLC (Grapevine) subsidiary. Pursuant to the Company s adoption of ASU 2009-16 *Accounting for Transfers of Financial Assets and Servicing Assets and Liabilities,* the Company began to include the activities of Grapevine into its consolidated financial statements effective January 1, 2010.

In connection with the ISOP plan, we record a non-cash variable stock-based compensation benefit or expense based on the performance of the fair value of our common stock. Variable stock-based compensation decreased by $2.5 million as a result of the decrease in share price during 2010.

General corporate expenses and other increased by $18.8 million from the prior year. The 2010 results include approximately $11.7 million of additional severance expense and $10.6 million of additional stock compensation compared to the prior year. These charges are primarily related to reductions in the Company s work force and the previously announced changes to the Company s executive management team.

Disposed Operations

Disposed Operations includes the remaining run out of the former Medicare Division and the former Other Insurance Division as well as the residual operations from the disposition of other businesses prior to 2009.

The table below sets forth income (loss) from continuing operations for our Disposed Operations for the years ended December 31, 2011, 2010 and 2009:

	For the Year Ended December 31,		
	2011	2010	2009
	(In thousands)		
Income (loss) from Disposed Operations before federal income taxes:			

Medicare Insurance Division	$424	$1,183	$(4,564)
Other Insurance Division	1,381	1,825	3,863
Operations disposed of prior to 2009	(78)	15	(2,321)
Total Disposed Operations	$1,727	$3,023	$(3,022)

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Medicare Division

In 2007, we expanded into the Medicare market by offering a new portfolio of Medicare Advantage Private-Fee-for-Service Plans in selected markets in 29 states with calendar year coverage effective for January 1, 2008. In July 2008, we determined we would not continue to participate in this Medicare Advantage Private-Fee-for-Service Plans business as an underwriter after the 2008 plan year. As such, the results of operations for 2009 are not comparable to the results of operations for 2008.

Set forth below is certain summary financial and operating data for the Medicare Division for each of the three most recent fiscal years:

	For the Year Ended December 31,		
	2011	2010	2009
	(Dollars in thousands)		
Revenues:			
Earned premium revenue	$	$ (14)	$ 1,103
Investment income		2	136
Total revenues		(12)	1,239
Benefits and expenses:			
Benefits, claims and settlement expenses	(457)	(1,448)	5,707
Underwriting, acquisition and insurance expenses	33	253	96
Total expenses	(424)	(1,195)	5,803
Operating income (loss)	$ 424	$ 1,183	$ (4,564)

During 2009 we experienced a higher than expected claim volume and, as a result, we increased our claim liability to reflect this adverse experience. During 2010, as the claim activity began to subside, the Company refined its claim liability and decreased the lifetime loss ratio from 88.2% as of December 31, 2009 to 85.6% as of December 31, 2010. During 2011, generally all liabilities have been settled. We do not expect any material activity with this business in 2012.

Other Insurance

Our Other Insurance Division consisted of ZON-Re, an 82.5%-owned subsidiary, which underwrote, administered and issued accidental death, accidental death and dismemberment, accident medical, and accident disability insurance products, both on a primary and on a reinsurance basis. We distributed these products through professional reinsurance intermediaries and a network of independent commercial insurance agents, brokers and third party administrators. On June 5, 2009, HealthMarkets, LLC, entered into an Acquisition Agreement for the sale of its 82.5% membership interest in ZON-Re to Venue Re. The transaction contemplated by the Acquisition Agreement closed effective June 30, 2009. We will continue to reflect the existing insurance business on our financial statements to final termination of all liabilities.

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

	For the Year Ended December 31,		
	2011	2010	2009
	(In thousands)		
Revenues:			
Earned premium revenue	$ 34	$ 677	$ 5,515
Investment income	1,587	1,744	1,827
Other income		(4)	552
Total revenues	1,621	2,417	7,894
Expenses:			
Benefits, claims and settlement expenses	(145)	(1,398)	(808)
Underwriting, acquisition and insurance expenses	385	1,990	4,839
Total expenses	240	592	4,031
Operating income	$ 1,381	$ 1,825	$ 3,863

As disclosed in the table above, we recognized positive experience related to benefits expense as a result of favorable claims experience on the expired policies maturing during the periods, which policies were not renewed. We also recognized positive results as favorable claims experience was realized on contracts expiring prior to or during the period. Underwriting, acquisition and insurance expenses continue to decline reflecting our exit from this line of business.

Operations disposed of prior to 2009

This group incurred a loss of $78,000, income of $15,000 and a loss of $2.3 million in 2011, 2010 and 2009, respectively. The loss in 2009 primarily relates to certain additional costs incurred with our decision to exit the Life Insurance Division business.

Liquidity and Capital Resources

We regularly monitor our liquidity position, including cash levels, principal investment commitments, interest and principal payments on debt, capital expenditures and compliance with regulatory requirements. We maintain liquidity at two levels: our insurance subsidiaries and our holding company.

Our regulated domestic insurance subsidiaries generate significant cash flows from operations. Liquidity requirements at the insurance subsidiaries generally consist of claim and benefit payments to policyholders and operating expenses, primarily for employee compensation and benefits. The Company meets such requirements by maintaining appropriate levels of cash, cash equivalents and short-term investments, using cash flows from operating activities and selling investments. After considering expected cash flows from operating activities, we generally invest cash at our regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, marketable debt securities to improve our overall investment return. These investments are made after consideration of return objectives, regulatory limitations, tax implications and risk tolerances. Cash in excess of the capital needs of our domestic regulated insurance entities is paid to their non-regulated parent company, typically in the form of dividends, when and as permitted by applicable regulations.

The holding company generates cash flows primarily through dividends from its subsidiaries. Cash flows generated from dividends and through the issuance of long-term debt, further strengthen our operating and financial flexibility. Liquidity requirements at the holding company level generally consist of servicing debt, funding the start up costs of Insphere, reinvestments in our businesses through the expansion of our products and services and the repurchase of shares of our common stock.

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Consolidated Cash Flows

Historically, our primary source of cash on a consolidated basis has been premium revenue from policies issued. The primary uses of cash on a consolidated basis have been for the payment for benefits, claims and commissions under those policies, as well as operating expenses, primarily employee compensation and benefits.

	For the Year Ended December 31,		
	2011	2010	2009
		(In thousands)	
Cash Provided By (Used In):			
Operating activities:			
Net income	$ 10,747	$ 50,197	$ 17,724
Non-cash charges	32,274	63,106	72,146
Other operating activities	(20,711)	(146,786)	(104,422)
Net cash provided by (used in) operating activities	22,310	(33,483)	(14,552)
Investing activities	(539)	171,220	(49,638)
Financing activities	(17,346)	(142,269)	(18,743)
Net change in cash and cash equivalents	4,425	(4,532)	(82,933)
Cash and cash equivalents at beginning of period	12,874	17,406	100,339
Cash and cash equivalents at end of period	$ 17,299	$ 12,874	$ 17,406

Operating Activities

Cash flows generated from operating activities are principally from net income, net of depreciation and amortization and other non-cash expenses. During 2010 and 2009 the Company s operating activities used cash flows primarily as a result of the declining block of health insurance business and the costs incurred with the development of Insphere. In 2011, we generated cash flows primarily as a result of the reduction in development costs in Insphere and a reduction in salary and other employee costs as a result of work force reductions and compensation costs incurred as a result of changes in executive management in 2010.

Investing Activities

Cash flows from investing activities primarily consist of net investment purchases or sales and net purchases of property and equipment, including capitalized software. Investing activities for 2010 includes the redemption of invested assets used to pay a dividend in the amount of $118.5 million to shareholders during the year.

Financing Activities

Cash flows used in financing activities primarily consist of repurchases of treasury stock, repayment of the student loan credit facility and dividends to shareholders. Cash flows provided by financing activities primarily consist of proceeds from shares issued to the ISOP. In 2010, cash flows used in financing activities were primarily related to dividend payments to shareholders of $118.5 million.

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 the holding company). 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 HealthMarkets, LLC. HealthMarkets, LLC s principal assets are its investments in its separate operating subsidiaries, including its regulated domestic insurance subsidiaries.

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Set forth in the table below is the aggregate cash and cash equivalents and short-term investments held at HealthMarkets, Inc. and HealthMarkets, LLC:

	For the Year Ended December 31,		
	2011	2010	2009
		(In thousands)	
Cash, cash equivalents and short-term investments at:			
HealthMarkets, Inc.	$ 74,244	$ 67,171	$ 24,394
HealthMarkets, LLC.	376,061	101,235	217,771
Total	$ 450,305	$ 168,406	$ 242,165

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:

	For the Year Ended December 31,		
	2011	2010	2009
		(In thousands)	
Cash and cash equivalents and short-term investments on hand at beginning of year	$ 168,406	$ 242,165	$ 232,123
Sources of cash:			
Dividends from domestic insurance subsidiaries	308,500	96,900	68,800
Dividends from offshore insurance subsidiaries		5,000	3,000
Dividends from non-insurance subsidiaries	13,750	26,600	2,480
Proceeds from other financing activities	4,227	6,998	11,468
Net tax treaty payments from subsidiaries	29,009	50,292	26,669
Net investment activities		18,966	4,579
Total sources of cash	355,486	204,756	116,996
Uses of cash:			
Cash to operations	(20,147)	(39,890)	(37,387)
Contributions/investment in subsidiaries			(120)
Interest on debt	(12,472)	(18,756)	(25,143)
Financing activities	(30,363)	(91,697)	(23,152)
Dividends paid to shareholders		(118,454)	
Purchases of HealthMarkets common stock	(10,605)	(9,718)	(21,152)
Total uses of cash	(73,587)	(278,515)	(106,954)
Cash and cash equivalents on hand at end of year	$ 450,305	$ 168,406	$ 242,165

Sources of Cash and Liquidity

During 2011, 2010 and 2009, the holding company received an aggregate of $322.3 million, $128.5 million and $74.3 million, respectively, in cash dividends from its subsidiaries. The amount in 2011 includes an extraordinary dividend in the amount of $159.4 million paid form the Company s MEGA insurance subsidiary.

In 2011, 2010 and 2009, the holding company received $4.2 million, $7.0 million and $11.5 million, respectively, in proceeds from other financing activities largely consisting of $4.2 million, $6.9 million and $11.1 million, respectively, in proceeds to acquire shares in the ISOP or its predecessor plans.

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Uses of Cash and Liquidity

During 2011, 2010 and 2009, the holding company paid $10.6 million, $9.7 million and $21.1 million, respectively, to repurchase shares of its common stock from former officers and former and current participants of the ISOP or its predecessor plans.

In 2011, 2010 and 2009, the holding company paid $12.5 million, $18.8 million and $25.1 million, respectively in interest on outstanding debt.

During 2011, 2010 and 2009, the holding company used $30.4 million, $91.7 million and $23.1 million, respectively, in financing activities of which approximately $30.4 million, $90.7 million and $19.5 million, respectively, was used to fund Insphere operations.

During 2010, the holding company paid a special cash dividend of $118.5 million.

2010 Dividend to Shareholders

Effective February 25, 2010, the Board of Directors of HealthMarkets, Inc. declared a special dividend in the amount of $3.94 per share for Class A-1 and Class A-2 common stock to holders of record as of the close of business on March 1, 2010, payable on March 9, 2010. In connection with the special cash dividend, the Company paid dividends to stockholders in the aggregate of $118.5 million with an additional $661,000 of dividends associated with restricted stock options to be paid upon vesting of those restricted stock options and $399,000 dividend equivalents credited to the employee participant accounts in the ISOP.

Regulatory Requirements

The state of domicile of each of the Company s domestic insurance subsidiaries imposes minimum risk-based capital requirements that were developed by the NAIC. The formulas for determining the amount of risk-based capital specify various weighting factors that are applied to financial balances and premium levels based on the perceived degree of risk. Regulatory compliance is determined by a ratio of a company s regulatory total adjusted capital, as defined, to its authorized control level risk-based capital, as defined. Companies specific trigger points or ratios are classified within certain levels, each of which requires specified corrective action.

Generally, the total stockholders equity of domestic insurance subsidiaries (as determined in accordance with statutory accounting practices) in excess of minimum statutory capital requirements is available for transfer to the parent company. However, the amount of equity available for dividends in any given year without prior approval from state regulatory authorities is subject to certain limitations as discussed below under *Dividend Restrictions*.

The required minimum aggregate statutory capital and surplus of our principal domestic insurance subsidiaries were as follows at December 31, 2011:

	Minimum	Actual
	(In millions)	
Mega	$ 51.1	$ 110.5
Mid-West	$ 22.0	$ 73.7
Chesapeake	$ 8.0	$ 35.7

At December 31, 2011, the risk-based capital ratio of each of our insurance subsidiaries exceeds the ratio for which regulatory corrective action would be required.

Dividend Restrictions

We conduct a significant portion of our business through our insurance subsidiaries, which are subject to regulations and standards established by their respective states of domicile. Most of these regulations and standards conform to those established by the NAIC. These standards require our insurance subsidiaries to

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maintain specified levels of statutory capital, as defined by each state, and restrict the timing and amount of dividends and other distributions that may be paid to their parent company. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary, without prior approval by state regulatory authorities, is limited based on the entity s level of statutory net income and statutory capital and surplus. These limitations are based upon the greater of 10% of statutory surplus at the end of the preceding year or the preceding year s statutory gain from operations.

Our domestic insurance companies paid dividends of $308.5 million, $96.9 million and $68.8 million, respectively, to HealthMarkets, LLC in 2011, 2010 and 2009, respectively. The dividend amount for 2011 includes $159.4 million of extraordinary dividends paid from the Company s MEGA insurance subsidiary.

In January 2012, the Company s Mid-West insurance subsidiary paid an extraordinary dividend in the amount of $30.0 million to its parent, HealthMarkets, LLC. During 2012, the Company s domestic insurance companies are eligible to pay additional aggregate dividends in the ordinary course of business to HealthMarkets, LLC of approximately $48.1 million without prior approval by statutory authorities. However, as it has done in the past, the Company will continue to assess the results of operations of the regulated domestic insurance companies to determine the prudent dividend capability of the subsidiaries. This is consistent with our practice of maintaining risk-based capital ratios at each of our domestic insurance subsidiaries in excess of minimum requirements.

Contractual Obligations and Off Balance Sheet Arrangements

The following table sets forth additional information with respect to our outstanding debt:

	Maturity Date	December 31, 2011	2010
		(In thousands)	
2006 credit agreement:			
Term loan	2012	$ 362,500	$ 362,500
Grapevine Note	2021	72,350	72,350
Trust preferred securities:			
UICI Capital Trust I	2034	15,470	15,470
HealthMarkets Capital Trust I	2036	51,550	51,550
HealthMarkets Capital Trust II	2036	51,550	51,550
Total		$ 553,420	$ 553,420
Student Loan Credit Facility		60,050	68,650
Total		$ 613,470	$ 622,070

In April 2006, we borrowed $500.0 million under a term loan credit facility and issued $100.0 million of Floating Rate Junior Subordinated Notes. The Company made principal payments on the term loan and, at December 31, 2011, $362.5 million remained outstanding. The maturity date of the term loan is April 5, 2012. On February 29, 2012, the Company paid in full the remaining principal and interest on the term loan in an amount of $363.3 million.

Grapevine Finance LLC issued $72.4 million of senior secured notes to an institutional purchaser which matures in July 2021. The net proceeds were distributed to HealthMarkets, LLC. The note bears interest at an annual rate of 6.712%. The interest is to be paid semi-annually on January 15th and July 15th of each year.

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In April 2006, HealthMarkets Capital Trust I and HealthMarkets Capital Trust II (Trusts) issued $100.0 million of floating rate trust preferred securities and $3.1 million of floating rate common securities and invested the proceeds in $100.0 million principal amount of HealthMarkets, LLC s floating rate junior subordinated notes due June 15, 2036. The notes accrue interest at a floating rate equal to three-month LIBOR plus 3.05%.

In April 2004, UICI Capital Trust I completed the private placement of $15.0 million amount of floating rate trust preferred securities and $470,000 of floating rate common securities and invested the proceeds in an equivalent face amount of the Company s floating rate junior subordinated notes due 2034. The notes will mature on April 29, 2034 and accrue interest at a floating rate equal to three-month LIBOR plus 3.50%, payable quarterly.

At December 31, 2011, the Company had indebtedness outstanding under a secured student loan credit facility which indebtedness is represented by Student Loan Asset-Backed Notes issued by a bankruptcy-remote special purpose entity. Indebtedness outstanding under the Student Loan Credit Facility is secured by student loans and accrued interest and by a pledge of cash, cash equivalents and other qualified investments.

Set forth below is a summary of our consolidated contractual obligations at December 31, 2011:

	Payment Due by Period				
	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
			(In thousands)		
Corporate debt	$ 553,420	$ 362,500	$	$	$ 190,920
Student Loan Credit Facility	60,050	7,300	12,050	10,150	30,550
Future policy benefits(1)	473,163	26,799	53,961	45,580	346,823
Claim liabilities(1)	94,743	84,616	9,011	772	344
Student loan commitments(2)	56,320	3,765	11,284	12,937	28,334
Goldman Sachs Real Estate Partners, L.P.	1,617		1,617		
Blackstone Strategic Alliance Fund L.P.	317	317			
Operating lease obligations	11,431	3,963	5,162	2,166	140
Total	$ 1,251,061	$ 489,260	$ 93,085	$ 71,605	$ 597,111

(1) In connection with various reinsurance agreements the Company entered into coinsurance arrangements pursuant to which the reinsurers agreed to assume liability for $337.5 million of future policy benefits and $19.5 million of claim liabilities associated with such businesses.

(2) The Company has outstanding commitments to fund student loans through 2026 for an aggregate amount of $56.3 million. However, based upon utilization rates and policy lapse rates, the Company only expects to fund $1.0 million.

Critical Accounting Policies and Estimates

Our discussion and analysis of the consolidated financial condition and results of operations are based upon the consolidated financial statements, which have been prepared in accordance with generally accepted accounting principles in the United States of America (GAAP). The preparation of these financial statements requires us 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, we evaluate our estimates, including those related to health and life insurance claims, bad debts, investments, intangible assets, income taxes, financing operations and contingencies and litigation. We base our estimates on historical experience, as well as various other assumptions that we believe 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 apparent from other sources. Actual results may differ from these estimates under different assumptions or conditions.

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We believe the following critical accounting policies affect the more significant judgments and estimates used in the preparation of our consolidated financial statements, which are discussed in more detail below:

- the valuations of certain assets and liabilities require fair value estimates;
- recognition of premium revenue;
- recognition of commission revenue;
- the estimate of claim liabilities;
- the realization of deferred acquisition costs;
- the carrying amount of goodwill and other intangible assets;
- the amortization period of intangible assets;
- stock-based compensation plan forfeitures;
- the realization of deferred taxes;
- reserves for contingencies, including reserves for losses in connection with unresolved legal and regulatory matters; and
- other matters that affect the reported amounts and disclosure of contingencies in the financial statements.

Estimates, by their nature, are based on judgment and available information. Therefore, actual results could differ from those estimates and could have a material impact on the consolidated financial statements.

Fair Value Measurements

We account for our investments and certain other assets and liabilities recorded at fair value in accordance with Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurements and Disclosures* (ASC 820), which requires us to categorize such assets and liabilities into a three-level hierarchy. As discussed in more detail below, the determination of fair value for certain assets and liabilities may require the application of a greater degree of judgment given recent volatile market conditions, as the ability to value assets can be significantly impacted by a decrease in market activity. We evaluate the various types of securities in our investment portfolio to determine the appropriate level in the fair value hierarchy based upon trading activity and the observability of market inputs. We employ control processes to validate the reasonableness of the fair value estimates of our assets and liabilities, including those estimates based on prices and quotes obtained from independent third party sources. Our procedures generally include, but are not limited to, initial and ongoing evaluation of methodologies used by independent third parties and monthly analytical reviews of the prices against current pricing trends and statistics.

Where possible, we utilize quoted market prices to measure fair value. For investments that have quoted market prices in active markets, we use the quoted market price as fair value and include these prices in the amounts disclosed in Level 1 of the hierarchy. When quoted market prices in

active markets are unavailable, we determine fair values using various valuation techniques and models based on a range of observable market inputs including pricing models, quoted market price of publicly traded securities with similar duration and yield, time value, yield curve, prepayment speeds, default rates and discounted cash flow. In most cases, these estimates are determined based on independent third party valuation information, and the amounts are disclosed in Level 2 of the fair value hierarchy. Generally, we obtain a single price or quote per instrument from independent third parties to assist in establishing the fair value of these investments.

If quoted market prices and independent third party valuation information are unavailable, we produce an estimate of fair value based on internally developed valuation techniques, which, depending on the level of observable market inputs, will render the fair value estimate as Level 2 or Level 3. On occasions when pricing

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service data is unavailable, we may rely on bid/ask spreads from dealers in determining the fair value. When dealer quotations are used to assist in establishing the fair value, we generally obtain one quote per instrument. The quotes obtained from dealers or brokers are generally non-binding. When dealer quotations are used, we use the mid-mark as fair value. When broker or dealer quotations are used for valuation or price verification, greater priority is given to executable quotes. As part of the price verification process, valuations based on quotes are corroborated by comparison both to other quotes and to recent trading activity in the same or similar instruments.

To the extent we determine that a price or quote is inconsistent with actual trading activity observed in that investment or similar investments, or if we do not think the quote is reflective of the market value for the investment, we will internally develop a fair value using this observable market information and disclose the occurrence of this circumstance.

Investments

We have classified our investments in securities with fixed maturities as available for sale Fixed maturities and equity securities have been recorded at fair value, and unrealized investment gains and losses are reflected in stockholders equity.

Investments are reviewed at least quarterly, using both quantitative and qualitative factors, to determine if they have experienced an impairment of value that is considered other-than-temporary. In its review, management 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. Additionally, we assess whether the amortized cost basis will be recovered by comparing the present value of cash flows expected to be collected with the amortized cost basis of the investment. When the determination is made that an other-than-temporary impairment (OTTI) exists but we do not intend to sell the security and it is not more likely than not that we will be required to sell the security before the recovery of its remaining amortized cost basis, we determine the amount of the impairment related to a credit loss and the amount related to other factors. OTTI losses attributed to a credit loss are recorded in Net impairment losses recognized in earnings on the statement of operations. OTTI losses attributed to other factors are reported in Accumulated other comprehensive income (loss) as a separate component of stockholders equity and accordingly have no effect on our net income (loss).

Testing for impairment of investments 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.

Upon our adoption of FSP SFAS No. 115-2 in the second quarter of 2009, which was codified into FASB ASC Topic 320*, Investments Debt and Equity Securities* (ASC 320), we recorded a cumulative-effect adjustment for debt securities held at adoption for which an OTTI had been previously recognized. We recognized such tax-effected cumulative effect of initially applying this guidance as an adjustment to Retained earnings for $1.0 million, net of tax, with a corresponding adjustment to Accumulated other comprehensive income.

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Premium Revenue

Health Premiums

Health insurance policies issued by the Company are considered long-duration contracts. The contract provisions generally cannot be changed or canceled during the contract period; however, the Company may adjust premiums for health policies issued within prescribed guidelines and with the approval of state insurance regulatory authorities. Insurance premiums for health policies are recognized as earned over the premium payment periods of the policies. Benefits and expenses are matched with premiums so as to result in recognition of income over the term of the contract. This matching is accomplished by means of the provision for future policyholder benefits and expenses and the deferral and amortization of acquisition costs.

Life Premiums

Premiums on traditional life insurance are recognized as revenue when due. Benefits and expenses are matched with premiums so as to result in recognition of income over the term of the contract. This matching is accomplished by means of the provision for future policyholder benefits and expenses and the deferral and amortization of acquisition costs.

Premiums and annuity considerations collected on universal life-type and annuity contracts are recorded using deposit accounting, and are credited directly to an appropriate policy reserve account, without recognizing premium income. Revenues from universal life-type and annuity contracts are amounts assessed to the policyholder for the cost of insurance (mortality charges), policy administration charges and surrender charges and are recognized as revenue when assessed based on one-year service periods. Amounts assessed for services to be provided in future periods are reported as unearned revenue and are recognized as revenue over the benefit period. Contract benefits that are charged to expense include benefit claims incurred in the period in excess of related contract balances and interest credited to contract balances.

Commission Revenues

Insphere and its agents distribute insurance products underwritten by the Company s insurance subsidiaries, as well as third-party insurance products underwritten by non-affiliated insurance companies. The Company earns commissions for third-party insurance products sold by Insphere agents. The majority of our commission revenue is derived from insurance policies and association memberships that are billed monthly. The Company also receives a small percentage of commission revenue based on quarterly, semi-annual, and annual billing modes. For all billing modes, the commission revenue is recognized as earned on a monthly basis beginning with the effective date of the insurance policy and continues as long as the policy continues to pay premium. For single premium annuity commission revenue, and other commissions that are received on a one-time basis, commission revenues are recognized as of the effective date of the insurance policy or the date on which the policy premium is billed to the customer, whichever is later. Subsequent commission adjustments are recognized upon our receipt of notification concerning matters necessitating such adjustments from the insurance companies. Production bonuses, volume overrides and contingent commissions are recognized when determinable, either (i) when such commissions are received from insurance companies, (ii) when we receive formal notification of the amount of such payments or (iii) when the amounts of such payments can be reasonably estimated.

Acquisition Costs

Deferred Acquisition Costs (DAC)

We incur 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). We defer these costs and amortize the deferred expense over the expected premium paying period of the policy, which approximates five years. Additionally, certain

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underwriting and policy issuance costs, which we determined to be more variable than fixed in nature are capitalized and amortized over the expected premium paying period of the policy. We also defer commissions paid to agents and premium taxes with respect to the portion of health premium collected but not yet earned.

The calculation of DAC requires us to use estimates based on actuarial valuation techniques. We review our actuarial assumptions and deferrable acquisition costs each year and, when necessary, we revise such assumptions to more closely reflect recent experience. For policies in force, we evaluate DAC to determine whether such costs are recoverable from future revenues. Any resulting adjustment is charged against net earnings.

Goodwill and Other Identifiable Intangible Asset

We account for goodwill and other intangibles in accordance with FASB ASC Topic 350, *Intangibles Goodwill and Other* (ASC 350), which requires that goodwill and other intangible assets be tested for impairment at least annually or more frequently if certain indicators arise. An impairment loss would be recorded in the period such determination was made. Consistent with prior years, we use assumptions and estimates in our valuation, and actual results could differ from those estimates. ASC 350 also requires that intangible assets with estimable useful lives be amortized over their respective estimated useful lives to their estimated residual values. Management makes assumptions regarding the useful lives assigned to intangible assets. We currently amortize intangible assets with estimable useful lives over a period ranging from five to twenty-five years, however, management may revise amortization periods if they believe there has been a change in the length of time that an intangible asset will continue to have value. If these estimates or their related assumptions change in the future, we may be required to record impairment losses or change the useful life, including accelerating amortization for these assets.

Claims Liabilities

We establish 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 claims liabilities estimate is developed and 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. We do not develop ranges in the setting of the claims liabilities reported in the financial statements.

The majority of our claims 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 service dates of the claim payments. The completion factors are selected so that they are equally likely to be redundant as deficient.

Prior to 2011, the majority of health insurance products offered through the Commercial Health Division establish the claims liabilities using the modified incurred date. Under the modified 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. See *Change in Accounting Principle on Claim Liabilities* below for discussion on the change in methodology from the modified incurred date to service date.

Beginning in 2008, the Commercial Health Division began using date of service as opposed to the modified incurred date to establish the claims liabilities for new contracts introduced or updated in or after 2008.

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In estimating the ultimate level of claims for the most recent incurral months, we use what we believe 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 our 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.

We believe that the recorded claim liabilities are reasonable and adequate to satisfy its ultimate claims liability. We use our own experience as appropriate and rely on industry loss experience as necessary in areas where our data is limited. Our estimate of claim liabilities represents management s best estimate of the liability for each period presented.

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 the Commercial Health Division.

The following table illustrates the sensitivity of these factors and the estimated impact to the December 31, 2011 unpaid claim liability for the Commercial Health Division. The scenarios selected are reasonable based on the Company s past experience, however future results may differ.

Completion Factor(a)		Loss Ratio Estimate(b)	
Increase (Decrease) in Factor	Increase (Decrease) in Estimated Claim Liability (In thousands)	Increase (Decrease) in Ratio	Increase (Decrease) in Estimated Claim Liability (In thousands)
6%	$ (4,318)	6%	$ 4,113
4%	(2,879)	4%	2,742
2%	(1,440)	2%	1,371
-2%	1,441	-2%	(1,371)
-4%	2,882	-4%	(2,742)
-6%	4,325	-6%	(4,113)

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

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

Changes in Commercial Health Claim Liability Estimates

The Commercial Health Division reported particularly favorable experience development during the reporting periods on claims incurred in prior years in the reported values of subsequent years (see Note 8 of Notes to Consolidated Financial Statements for discussion of claims liability development experience). A significant portion of the favorable experience development was attributable to the recognition that the claims payment patterns used in establishing the completion factors were no longer reflective of the expected future claims payment patterns underlying the claim liability. As a result, we refined the estimates and assumptions used in calculating the claims liabilities estimate to accommodate the changing patterns as they emerge.

The Company continues to update its completion factors to reflect more recent patterns of claim payments. Throughout 2010, we saw an ongoing decrease in the time period from incurral to payment of a claim, resulting in higher completion factors and lower reserves. In response to these trends, we used more recent experience to develop the completion factors, resulting in a decrease in claim liabilities of $30.6 million recognized during the three months ended September 30, 2010. During 2011, the Company again updated its completion factors to

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reflect the more recent patterns of claim payments resulting in a decrease in the claim liabilities of $7.8 million in the three months ended September 30, 2011. We will continue to evaluate and update completion factors on an ongoing basis, as appropriate, and will evaluate the impact, if any, that Health Care Reform Legislation may have on the completion factors.

During the fourth quarter of 2010, we revised the loss development technique for the most recent incurral months. We revised our technique to use a Bornhuetter-Ferguson calculation which weights a completion factor estimate with an exposure-based estimate. The weights used are the completion factors, which results in a reserve estimate that is the reciprocal of the completion factor times the exposure-based estimate. The exposure-based estimate is the earned premium multiplied by the anticipated loss ratio, which in most cases is the 12-month average loss ratio for the months prior to the most recent incurral months. As a result of this revision, during the fourth quarter of 2010, we recognized a decrease in claim liabilities of $10.2 million.

The estimate with respect to claims liability and related benefit expenses are subject to an extensive degree of judgment. During the fourth quarter of 2009, based on a review of the claims processing for state mandated benefits, we refined the claim liability estimate related to state mandated benefits. Based on this review of submitted charges for state mandated benefits, we recorded a claim liability estimate of $23.9 million ($25.7 million including loss adjustment expense).

During 2010, we adjusted the estimated claim liability established in the fourth quarter of 2009 related to the review of claims processing for state mandated benefits based upon actual results from reprocessing approximately 81% of these claims. As a result of this refinement, during 2010, we recognized a decrease in the claims liabilities of $19.6 million.

Change in Accounting Principle on Claim Liabilities

Effective January 1, 2011, the Company changed the method used to calculate its policy liabilities for the majority of its health insurance products because it believes that the new method will be preferable in light of, among other factors, certain changes required by Health Care Reform Legislation.

For the majority of health insurance products in the Commercial Health Division, the Company s claims liabilities are estimated using the developmental method. The Company establishes the claims liabilities based upon claim incurral dates, supplemented with certain refinements as appropriate. Prior to January 1, 2011, for products introduced prior to 2008, the Company used a technique for calculating claims liabilities referred to as the Modified Incurred Date (MID) technique. Under the MID technique, claims liabilities for the cost of all medical services related to a distinct accident or sickness are based on 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. Claims liabilities based on the earliest date of diagnosis generally result in larger initial claims liabilities which complete over a longer period of time than claims estimation techniques using dates of service. Under the MID technique, the Company modifies the original incurred date coding by establishing a new incurral date if: (i) there is a break of more than six months in the occurrence of a covered benefit service or (ii) if claims payments continue for more than thirty-six months without a six month break in service.

For products introduced in 2008 and later, claims payments were considered incurred on the date the service is rendered, regardless of whether the sickness or accident is distinct or the same. This is referred to as the Service Date (SD) technique. This is consistent with the assumptions used in the pricing of these products and the policy language. At December 31, 2010, the Company had claims liabilities for products using the SD technique in the amount of $10.6 million, representing approximately 8% of the total claims liabilities of the Commercial Health Division. The use of the SD technique in establishing claims liabilities requires the establishment of a future policy benefit reserve while the MID technique does not. For the reasons discussed below, we believe that it is preferable to estimate the Company s claims liabilities using the SD technique, and to apply such technique for claims liabilities previously calculated based on the MID technique.

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As previously disclosed, in March 2010, Health Care Reform Legislation was signed into law. The Health Care Reform Legislation requires, beginning in 2011, a mandated minimum loss ratio (MLR) of 80% for the individual and small group markets. If MLR is below the mandated minimum, the Health Care Reform Legislation generally requires that the insurer return the amount of premium that is in excess of the required MLR to the policyholder in the form of rebates. The MLR is calculated for each of our insurance subsidiaries on a state-by-state basis in each state where the Company has issued major medical business. Department of Health and Human Services (HHS) rules indicate that the MLR calculation shall utilize data on incurred claims for the calendar year, paid through March of the following year.

Any refund of premiums in excess of the required MLR will be based on the completion of claims three months after the calendar year end. Based on the MLR calculation requiring only three additional months of claims and the SD technique being the most prevalent method of estimating claims liabilities in the health insurance industry, the Company believes that the SD technique is the preferable method for calculating the MLR. The Company also believes that using the SD method for the settlement of the MLR calculation will reduce uncertainty regarding the ultimate amount of incurred claims, as the MID technique estimates claims over a longer settlement period. The calculation of the MLR using the Company s current data results in claims for a given incurred year that are approximately 95% complete three months after the valuation date using the SD technique, whereas claims are approximately 82% complete 3 months after the valuation date using the MID technique. Additionally, the use of the MID technique for financial reporting purposes, with the settlement of the MLR calculated on a SD basis, may result in an over accrual of the claims liabilities on the financial statements as a result of the Company s accrual for rebates in the MLR calculation.

In light of the changes resulting from the Health Care Reform Legislation, and given that the Company s insurance contracts would support the use of either reserving technique, the Company, after discussions with its domiciliary insurance regulators on the preferred methodology for calculating rebates under the MLR requirements of the Health Care Reform Legislation, determined that the SD method is preferable in determining the estimation of its claims liabilities. For the in-force policies utilizing the MID technique for estimation of claims liabilities, effective January 1, 2011, the Company changed the method used to calculate its claims liabilities from the MID technique to the SD technique. Consistent with the Company s products introduced in 2008 and later, the Company established a reserve for future policy benefits for products introduced prior to 2008.

The Company has determined it is impracticable to determine the period-specific effects of the change in reserving methodology from MID to SD on all prior periods since retrospective application requires significant estimates of amounts and it is impossible to distinguish objectively information about those estimates at previous reporting dates. Based on the guidance of *ASC 250-10-45 Accounting Changes Change in Accounting Principle* if the cumulative effect of applying a change in accounting principle to all prior periods is determinable, but it is impracticable to determine the period-specific effects of that change to all prior periods presented, the cumulative effect of the change to the new accounting principle shall be applied to the carrying amounts of assets and liabilities as of beginning of the earliest period to which the new accounting principle can be applied. As such the Company accounted for the change effective January 1, 2011 by recording the cumulative effect of the change in accounting at that date.

Effective January 1, 2011, as a result of this change, the Company recorded the following: (i) a decrease in the amount of $77.9 million to claims and claims administration liabilities, (ii) an increase in the amount of $35.1 million to future policy and contract benefits, (iii) an increase in the amount of $15.0 million to deferred federal income tax liability and (iv) an increase in the amount of $27.8 million to retained earnings.

Accounting for ISOP

Historically, we have sponsored a series of stock accumulation plans established for the benefit of our independent insurance agents and independent sales representatives. In connection with the reorganization of the Company s agent sales force into an independent career-agent distribution company, and the launch of Insphere,

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effective January 1, 2010, these plans were superseded and replaced by the HealthMarkets, Inc. InVest Stock Ownership Plan (the ISOP). Generally, unvested benefits under the ISOP vest in January of each year. We have established a liability for future unvested benefits under the ISOP, and we adjust such liability based on the fair value of our common stock. As such, we have experienced, and will continue to experience, unpredictable stock-based compensation charges, depending upon fluctuations in the fair value of HealthMarkets common stock. These unpredictable fluctuations in stock-based compensation charges may result in material non-cash fluctuations in our earnings (see Note 13 of Notes to Consolidated Financial Statements).

Deferred Taxes

We record deferred tax assets to reflect the impact of temporary differences between the financial statement carrying amounts and tax basis of assets. Realization of the net deferred tax asset is dependent on generating sufficient future taxable income. The amount of the deferred tax asset considered realizable, however, could be reduced in the near term if estimates of future taxable income during the carryforward period are reduced.

We establish a valuation allowance when management believes, based on the weight of the available evidence, that it is more likely than not that all or some portion of the deferred tax asset will not be realized. We consider future taxable income and ongoing prudent and feasible tax planning strategies in assessing the continued need for a recorded valuation allowance. Establishing or increasing the valuation allowance would result in a charge to income in the period such determination was made. In the event we were to determine that we would be able to realize our deferred tax assets in the future in excess of its net recorded amount, an adjustment to the deferred tax asset would increase income in the period such determination was made.

Loss Contingencies

We are subject to proceedings and lawsuits related to insurance claims, regulatory issues, and other matters (see Note 16 of Notes to Consolidated Financial Statements). We are required to assess the likelihood of any adverse judgments or outcomes to these matters, as well as potential ranges of probable losses. A determination of the amount of accruals required, if any, for these contingencies is made after careful analysis of each individual issue. The required accruals may change in the future due to new developments in each matter or changes in approach, such as a change in settlement strategy in dealing with these matters.

Risk Management

HealthMarkets encounters risk in the normal course of business, and therefore, we have designed risk management processes to help manage such risks. The Company is subject to varying degrees of market risks, inflation risk, operational risks and liquidity risks (see Liquidity and Capital Resources discussion above) and monitors these risks on a consolidated basis.

Market Risks

Our assets and liabilities, including financial instruments, are subject to the risk of potential loss arising from adverse changes in market rates and prices. Market risk is directly influenced by the volatility and liquidity in the markets in which the related underlying assets are traded.

Sensitivity analysis is defined as the measurement of potential loss in future earnings, fair values or cash flows of market sensitive instruments resulting from one or more selected hypothetical changes in interest rates and other market rates or prices over a selected time. In our sensitivity analysis model, a hypothetical change in market rates is selected that is expected to reflect reasonably possible near-term changes in those rates. Near term is defined as a period of time going forward up to one year from the date of the consolidated financial statements.

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In this sensitivity analysis model, we use fair values to measure its potential loss. The primary market risk to our market sensitive instruments is interest rate risk. The sensitivity analysis model uses a 100 basis point change in interest rates to measure the hypothetical change in fair value of financial instruments included in the model. For invested assets, duration modeling is used to calculate changes in fair values. Duration on invested assets is adjusted to call, put and interest rate reset features.

The sensitivity analysis model decreases the gain in fair value of market sensitive instruments by $10.4 million based on a 100 basis point increase in interest rates as of December 31, 2011. This decreased value only reflects the impact of an interest rate increase on the fair value of our financial instruments.

At December 31, 2011, the Company had $481.1 million of debt exposed to the fluctuation of the three-month London Inter-bank Offer Rate (LIBOR) and is comprised of the term loan, UICI Capital Trust I note and the HealthMarkets Capital Trust I and II notes. The sensitivity analysis shows that if the three-month LIBOR rate changed by 100 basis points (1%), our interest expense would change by approximately $4.8 million.

Our Investment Committee monitors the investment portfolio of the Company and its subsidiaries. The Investment Committee receives investment management services from our in-house investment management team. The internal investment management team directly manages the investment assets.

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, we invest in a range of assets, but limit our investments in certain classes of assets, and limit our exposure to certain industries and to single issuers.

Fixed maturity securities represented 40.6% and 64.6% of our total investments at December 31, 2011 and 2010, respectively. At December 31, 2011, fixed maturity securities consisted of the following:

	December 31, 2011	
	Carrying Value	% of Total Carrying Value
	(Dollars in thousands)	
U.S. and U.S. Government agencies	$ 24,602	5.7%
Corporate bonds and municipals	252,279	58.9%
Mortgage-backed securities issued by U.S. Government agencies and authorities	46,940	11.0%
Other mortgage and asset backed securities	15,007	3.5%
Other	89,371	20.9%
Total fixed maturity securities	$ 428,199	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 held by its insurance company subsidiaries 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, 2011, the largest concentration in any one investment grade corporate bond held by an insurance company subsidiary was $105.6 million ($94.8 million face value), which represented 10.0% of total invested assets. This security was received as payment on the sale of our Student Insurance Division. To limit its credit risk, we have taken out $75.0 million of credit default insurance on this bond, reducing our default exposure to $19.8 million, or 1.9% of total invested assets. The largest concentration in any one non-investment grade corporate bond was $4.9 million, which represented less than 1% of total invested assets. The largest concentration to any one industry was less than 10%. Additionally, due primarily to long standing conservative investment guidelines, our direct exposure to sub prime investments is 0.1% of investments.

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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 our credit risk, we invest in mortgage-backed securities that are rated investment grade by the public rating agencies. Our 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. We seek to minimize prepayment risk during periods of declining interest rates and minimize duration extension risk during periods of rising interest rates. We have less than 1% of our investment portfolio invested in the more volatile tranches.

A quality distribution for fixed maturity securities at December 31, 2011 is set forth below:

	December 31, 2011	
Rating	Carrying Value	% of Total Carrying Value
	(Dollars in thousands)	
U.S. Government and AAA	$ 100,529	23.5%
AA	30,216	7.1%
A	170,339	39.8%
BBB	118,434	27.6%
Less than BBB	8,681	2.0%
	$ 428,199	100.0%

We regularly monitor our investment portfolio to attempt to minimize our 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 our aggregate investment portfolio at December 31, 2011 and 2010, excluding investments in U.S. Government securities:

	December 31,			
	2011		2010	
	Carrying Amount	% of Total Carrying Value	Carrying Amount	% of Total Carrying Value
	(Dollars in thousands)			
Issuer Fixed Maturities:				
UnitedHealth Group(1)	$ 105,565	10.0%	$ 101,301	9.6%
Cigna Corporation(2)	89,371	8.5%	86,392	8.2%
Exelon	5,149	0.5%	14,944	1.4%
Issuer Short-term investments (3):				
Fidelity Institutional Money Market	$		$ 208,208	19.8%
Fidelity Institutional Government Fund	478,841	45.4%	94,277	9.0%
Invesco STIT Government Fund	89,215	8.5%		
First American Treasury Obligations Fund	37,797	3.6%	37,767	3.6%

(1) Represents $94.8 million face value security received from the purchaser as consideration upon sale of our former Student Insurance Division on December 1, 2006. To reduce our credit risk, we have taken out $75.0 million of credit default insurance on this security, reducing our default exposure to $19.8 million.

(2) Represents $78.4 million face value security received from the purchaser as consideration upon sale of our former Star HRG Division in July 2006. This security is held in a bankruptcy remote entity with the Company s exposure limited to its residual investment of

approximately $7.2 million at December 31, 2011.

(3) Funds are diversified institutional money market funds that invest solely in United States dollar denominated money market securities.

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Inflation Risk

Inflation historically has had a significant impact on the health insurance business. In recent years, inflation in the costs of medical care covered by such insurance has exceeded the general rate of inflation. Under basic hospital medical insurance coverage, established ceilings for covered expenses limit the impact of inflation on the amount of claims paid. Under catastrophic hospital expense plans and preferred provider contracts, covered expenses are generally limited only by a maximum lifetime benefit and a maximum lifetime benefit per accident or sickness. Therefore, inflation may have a significantly greater impact on the amount of claims paid under catastrophic hospital expense and preferred provider plans as compared to claims under basic hospital medical coverage. As a result, trends in healthcare costs must be monitored and rates adjusted accordingly. Under the health insurance policies issued in the self-employed market, the primary insurer generally has the right to increase rates upon 30-60 days written notice and subject to regulatory approval in some cases.

The annuity and universal life-type policies issued directly and assumed by HealthMarkets are significantly impacted by inflation. Interest rates affect the amount of interest that existing policyholders expect to have credited to their policies. However, we believe that our annuity and universal life-type policies are generally competitive with those offered by other insurance companies of similar size, and the investment portfolio is managed to minimize the effects of inflation.

Operational Risks

Operational risk is inherent in our business and may, for example, manifest itself in the form of errors, breaches in the system of internal controls, business interruptions, fraud or legal actions due to operating deficiencies or noncompliance with regulatory requirements. We maintain a framework, including policies and a system of internal controls designed to monitor and manage operational risk, and provide management with timely and accurate information.

Privacy Initiatives

The business of insurance is primarily regulated by the states and is affected by a range of legislative developments at both the state and federal levels. Legislation and regulations governing the use and security of individuals nonpublic personal data by financial institutions, including insurance companies, may have a significant impact on the financial condition and results of operations. See Item 1. Business Regulatory and Legislative Matters.

Recently Issued Accounting Pronouncements

See Recent Accounting Pronouncements in Note 2 of Notes to Consolidated Financial Statements for information regarding new accounting pronouncements.

Item 7A. ***Quantitative and Qualitative Disclosures about Market Risk***

Quantitative and qualitative disclosures about market risk are included under the caption Management s Discussion and Analysis of Financial Condition and Results of Operations Risk Management.

Item 8. ***Financial Statements and Supplementary Data***

The audited consolidated financial statements of the Company and other information required by this Item 8 are included in this Form 10-K beginning on page F-1.

Item 9. ***Changes in and Disagreements with Accountants on Accounting and Financial Disclosure***

None.

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Item 9A. ***Controls and Procedures***

Disclosure Controls and Procedures

The Company maintains a set of disclosure controls and procedures designed to ensure that information required to be disclosed in reports that it files or submits under the Securities Exchange Act of 1934, as amended (the Exchange Act), is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission rules and forms. In addition, the disclosure controls and procedures ensure that information required to be disclosed is accumulated and communicated to management, including the principal executive officer and principal financial officer, allowing timely decisions regarding required disclosure. Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of our disclosure controls and procedures, as such term is defined under Rule 13a-15(e) promulgated under the Exchange Act. Based on this evaluation, our principal executive officer and our principal financial officer concluded that our disclosure controls and procedures were effective as of the end of the period covered by this annual report.

Management s Report on Internal Control over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f). The Company s internal control system was designed to provide reasonable assurance to the Company s management and its Board of Directors regarding the preparation and fair presentation of published financial statements. However, internal control systems, no matter how well designed cannot provide absolute assurance. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

The Company s management assessed the effectiveness of the Company s internal control over financial reporting as of December 31, 2011. Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework contained in *Internal Control Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO Report).

Based on our evaluation under the framework in the COSO Report our management concluded that our internal control over financial reporting was effective as of December 31, 2011.

This annual report does not include an attestation report of the Company s registered public accounting firm regarding internal control over financial reporting. Management s report was not subject to attestation by the Company s registered public accounting firm pursuant to rules of the Securities and Exchange Commission that permit the Company to provide only management s report in this annual report.

During the Company s fourth fiscal quarter, there has been no change in the Company s internal control over financial reporting that has materially affected, or is reasonably likely to materially affect, the Company s internal controls over financial reporting.

Item 9B. ***Other Information***

None.

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PART III

Item 10. ***Directors, Executive Officers and Corporate Governance***

See the Company s Information Statement to be filed in connection with the 2012 Annual Meeting of Stockholders, which is incorporated herein by reference.

For information on executive officers of the Company, reference is made to the item entitled Executive Officers of the Company in Part I of this report.

We have adopted a Code of Business Conduct and Ethics that applies to our employees, officers and directors, including our Chief Executive Officer, Chief Financial Officer, Principal Accounting Officer and Controller. The Code is available free of charge on our website at www.healthmarketsinc.com and in print to any stockholder who sends a request for a paper copy to: Corporate Secretary, HealthMarkets, Inc., 9151 Boulevard 26, North Richland Hills, Texas 76180. We intend to include on our website any amendment to, or waiver from, a provision of the Code of Business Conduct and Ethics that applies to our Chief Executive Officer, Chief Financial Officer, Principal Accounting Officer and Controller that relates to any element of the code of ethics definition enumerated in Item 406(b) of Regulation S-K.

Item 11. ***Executive Compensation***

See the Company s Information Statement to be filed in connection with the 2012 Annual Meeting of Stockholders, which is incorporated herein by reference.

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

See the Company s Information Statement to be filed in connection with the 2012 Annual Meeting of Stockholders, which is incorporated herein by reference.

Item 13. ***Certain Relationships and Related Transaction, and Director Independence***

See the Company s Information Statement to be filed in connection with the 2012 Annual Meeting of Stockholders, which is incorporated herein by reference. See Note 15 of Notes to Consolidated Financial Statements.

Item 14. ***Principal Accountant Fees and Services***

See the Company s Information Statement to be filed in connection with the 2012 Annual Meeting of Stockholders, of which the subsection captioned Independent Registered Public Accounting Firm is incorporated herein by reference.

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PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

(a) *Financial Statements*

The following consolidated financial statements of HealthMarkets and subsidiaries are included in Item 8:

	Page
Report of Independent Registered Public Accounting Firm	F-2
Consolidated Balance Sheets December 31, 2011 and 2010	F-3
Consolidated Statements of Operations Years ended December 31, 2011, 2010 and 2009	F-4
Consolidated Statements of Stockholders Equity and Comprehensive Income (Loss) Years ended December 31, 2011, 2010 and 2009	F-5
Consolidated Statements of Cash Flows Years ended December 31, 2011, 2010 and 2009	F-6
Notes to Consolidated Financial Statements	F-7

Financial Statement Schedules

Schedule II	Condensed Financial Information of Registrant December 31, 2011, 2010 and 2009: HealthMarkets (Holding Company)	F-83
Schedule III	Supplementary Insurance Information	F-86
Schedule IV	Reinsurance	F-88
Schedule V	Valuation and Qualifying Accounts	F-89

All other schedules for which provision is made in the applicable accounting regulations of the Securities and Exchange Commission are not required under the related instructions or are not applicable and therefore have been omitted.

Exhibits:

The response to this portion of Item 15 is submitted as a separate section of this 10-K entitled Exhibit Index.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

HealthMarkets, Inc.

By: /s/ Kenneth J. Fasola*
Kenneth J. Fasola
Chief Executive Officer

Date: March 8, 2012

Pursuant to the requirements of Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ KENNETH J. FASOLA*	Chief Executive Officer, President and	March 8, 2012
Kenneth J. Fasola	Director	
/s/ K. ALEC MAHMOOD	Senior Vice President and Chief	March 8, 2012
K. Alec Mahmood	Financial Officer	
/s/ CONNIE PALACIOS*	Vice President, Controller and Principal	March 8, 2012
Connie Palacios	Accounting Officer	
/s/ PHILLIP J. HILDEBRAND*	Chairman of the Board	March 8, 2012
Phillip J. Hildebrand		
/s/ CHINH E. CHU*	Director	March 8, 2012
Chinh E. Chu		
/s/ JASON K. GIORDANO*	Director	March 8, 2012
Jason K. Giordano		
/s/ ADRIAN M. JONES*	Director	March 8, 2012
Adrian M. Jones		
/s/ MURAL R. JOSEPHSON*	Director	March 8, 2012
Mural R. Josephson		
/s/ DAVID K. MCVEIGH*	Director	March 8, 2012
David K. McVeigh		
/s/ STEVEN J. SHULMAN*	Director	March 8, 2012

Steven J. Shulman		
/s/ R. NEAL POMROY*	Director	March 8, 2012
R. Neal Pomroy		
*By: /s/ K. ALEC MAHMOOD	Attorney-in-fact	March 8, 2012
K. Alec Mahmood		
(Attorney-in-fact)		

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ANNUAL REPORT ON FORM 10-K

ITEM 8, ITEM 15(A)(1) and (2), (C), and (D)

FINANCIAL STATEMENTS and SUPPLEMENTAL DATA

FINANCIAL STATEMENT SCHEDULES

CERTAIN EXHIBITS

FOR THE YEAR ENDED DECEMBER 31, 2011

HEALTHMARKETS, INC.

and

SUBSIDIARIES

NORTH RICHLAND HILLS, TEXAS

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors

HealthMarkets, Inc.:

We have audited the accompanying consolidated balance sheets of HealthMarkets, Inc. and subsidiaries (the Company) as of December 31, 2011 and 2010, and the related consolidated statements of operations, consolidated statements of stockholders equity and comprehensive income (loss), and consolidated statements of cash flows for each of the years in the three-year period ended December 31, 2011. In connection with our audits of the consolidated financial statements, we have also audited the financial statement schedules as listed in the Index at Item 15(a). These consolidated financial statements and financial statement schedules are the responsibility of the Company s management. Our responsibility is to express an opinion on these consolidated financial statements and financial statement schedules based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of HealthMarkets, Inc. and subsidiaries as of December 31, 2011 and 2010, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2011, in conformity with U.S. generally accepted accounting principles. Also, in our opinion, the related financial statement schedules, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly, in all material respects, the information set forth therein.

As described in note 2 to the consolidated financial statements, effective January 1, 2011 the Company changed its method of accounting for claim liabilities from the modified incurred date reserving method to the service date reserving method.

KPMG LLP

Dallas, Texas

March 8, 2012

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HEALTHMARKETS, INC.

and Subsidiaries

CONSOLIDATED BALANCE SHEETS

	December 31, 2011	2010
	(In thousands, except per share data)	
ASSETS		
Investments:		
Securities available for sale		
Fixed maturities, at fair value (cost: 2011 $394,948; 2010 $644,661)	$ 428,199	$ 679,405
Short-term and other investments	626,415	373,023
Total investments	1,054,614	1,052,428
Cash and cash equivalents	17,299	12,874
Student loan receivables	50,733	60,312
Restricted cash	14,447	13,170
Investment income due and accrued	4,007	7,139
Reinsurance recoverable ceded policy liabilities	363,139	363,243
Agent and other receivables	21,416	32,508
Deferred acquisition costs	17,764	32,689
Property and equipment, net	37,466	43,738
Goodwill and other intangible assets	80,255	82,331
Recoverable federal income taxes		3,443
Other assets	13,478	15,776
Assets Held for Sale	2,100	
	$ 1,676,718	$ 1,719,651
LIABILITIES AND STOCKHOLDERS EQUITY		
Policy liabilities:		
Future policy and contract benefits	$ 473,163	$ 453,773
Claims	94,743	208,675
Unearned premiums	27,523	34,862
Other policy liabilities	34,167	7,687
Accounts payable and accrued expenses	30,852	38,131
Other liabilities	57,107	58,868
Current income taxes payable	410	
Deferred income taxes payable	69,975	58,883
Debt	553,420	553,420
Student loan credit facility	60,050	68,650
Net liabilities of discontinued operations	1,486	1,574
	1,402,896	1,484,523
Commitments and Contingencies (Note 16)		
Stockholders Equity:		
Preferred stock, par value $0.01 per share authorized 10,000,000 shares, none issued		
Common Stock, Class A-1, par value $0.01 per share authorized 90,000,000 shares, 28,156,278 issued and 27,851,301outstanding at December 31, 2011 and 90,000,000 shares, 28,281,859 issued and 28,256,028 outstanding at December 31, 2010. Class A-2, par value $0.01 per share authorized 20,000,000 shares, 4,026,104 issued and 2,776,985 outstanding at December 31, 2011; 20,000,000 shares, 4,026,104 issued and 2,762,100 outstanding at December 31, 2010	322	323
Additional paid-in capital	50,535	54,772
Accumulated other comprehensive income	21,838	21,981
Retained earnings	216,884	178,313
	(15,757)	(20,261)

Treasury stock, at cost (304,977 Class A-1 common shares and 1,249,119 Class A-2 common shares at December 31, 2011; 25,831 Class A-1 common shares and 1,264,004 Class A-2 common shares at December 31, 2010)		
	273,822	235,128
	$ 1,676,718	$ 1,719,651

See accompanying notes to consolidated financial statements.

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HEALTHMARKETS, INC.

and Subsidiaries

CONSOLIDATED STATEMENTS OF OPERATIONS

	For the Year Ended December 31,		
	2011	2010	2009
	(In thousands, except per share data)		
REVENUE			
Health premiums	$ 543,092	$ 735,538	$ 977,568
Life premiums and other considerations	1,565	1,913	2,381
	544,657	737,451	979,949
Investment income	28,028	42,246	43,166
Commissions and other income	83,570	76,906	62,401
Net impairment losses recognized in earnings		(765)	(4,504)
Realized gains, net	8,942	5,815	2,385
	665,197	861,653	1,083,397
BENEFITS AND EXPENSES			
Benefits, claims, and settlement expenses	359,424	366,644	584,878
Underwriting, acquisition and insurance expenses (includes amounts paid to related parties of $512, $517 and $5,893 in 2011, 2010 and 2009, respectively)	101,441	173,830	338,028
Other expenses, (includes amounts paid to related parties of $15,343, $21,412 and $15,079 in 2011, 2010 and 2009, respectively)	163,540	209,070	98,821
Interest expense	22,082	30,082	32,432
	646,487	779,626	1,054,159
Income from continuing operations before income taxes	18,710	82,027	29,238
Federal income tax expense	8,042	31,896	11,676
Income from continuing operations	10,668	50,131	17,562
Income from discontinued operations, (net of income tax expense of $43, $36, and $88 in 2011, 2010 and 2009, respectively)	79	66	162
Net income	$ 10,747	$ 50,197	$ 17,724
Basic earnings per share:			
Income from continuing operations	$ 0.35	$ 1.69	$ 0.59
Income from discontinued operations	0.00	0.00	0.01
Net income per share, basic	$ 0.35	$ 1.69	$ 0.60
Diluted earnings per share:			
Income from continuing operations	$ 0.34	$ 1.64	$ 0.58
Income from discontinued operations	0.00	0.00	0.01
Net income per share, diluted	$ 0.34	$ 1.64	$ 0.59

See accompanying notes to consolidated financial statements.

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HEALTHMARKETS, INC.

and Subsidiaries

CONSOLIDATED STATEMENTS OF STOCKHOLDERS EQUITY AND

COMPREHENSIVE INCOME (LOSS)

	Common Stock	Additional Paid-In Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	Treasury Stock	Total
			(In thousands)			
Balance at December 31, 2008	$ 310	$ 54,004	$ (41,970)	$ 227,686	$ (42,105)	$ 197,925
Comprehensive income (loss):						
Net income				17,724		17,724
Change in unrealized gains and losses on securities			64,488			64,488
Change in unrealized gains on cash flow hedging relationship			7,399			7,399
Deferred income tax expense			(25,161)			(25,161)
Comprehensive income			46,726	17,724		64,450
Adjustment to beginning balance, net of tax(1)			(1,017)	1,017		
Issuance of common stock	6	(6,674)			14,673	8,005
Vesting of Agent Plan credits		(5,796)			12,737	6,941
Issuance of restricted shares		(5,222)			5,222	
Stock-based compensation		7,703				7,703
Stock-based compensation tax expense		(1,673)				(1,673)
Purchase of treasury stock					(21,152)	(21,152)
Balance at December 31, 2009	$ 316	$ 42,342	$ 3,739	$ 246,427	$ (30,625)	$ 262,199
Comprehensive income (loss):						
Net income				50,197		50,197
Change in unrealized gains and losses on securities			22,311			22,311
Change in unrealized gains on cash flow hedging relationship			5,750			5,750
Deferred income tax expense			(9,819)			(9,819)
Comprehensive income			18,242	50,197		68,439
Adjustment to beginning balance (2)				1,203		1,203
Dividends				(119,514)		(119,514)
Issuance of common stock	2	(3,620)			10,662	7,044
Vesting of Agent Plan credits		(1,548)			8,457	6,909
Issuance of restricted shares	5	(968)			963	
Stock-based compensation		19,689				19,689
Stock-based compensation tax expense		(1,123)				(1,123)
Purchase of treasury stock					(9,718)	(9,718)
Balance at December 31, 2010	$ 323	$ 54,772	$ 21,981	$ 178,313	$ (20,261)	$ 235,128
Comprehensive income (loss):						
Net income				10,747		10,747
Change in unrealized gains and losses on securities			(1,559)			(1,559)
Change in unrealized gains on cash flow hedging relationship			1,340			1,340

Deferred income tax expense			76			76
Comprehensive income			(143)	10,747		10,604
Adjustment to beginning balance (3)				27,824		27,824
Issuance of common stock		(3,136)			7,430	4,294
Vesting of Agent Plan credits	2	(4,087)			7,671	3,586
Issuance of restricted shares	(3)	3				
Stock-based compensation		3,776				3,776
Stock-based compensation tax expense		(793)				(793)
Purchase of treasury stock					(10,597)	(10,597)
Balance at December 31, 2011	$ 322	$ 50,535	$ 21,838	$ 216,884	$ (15,757)	$ 273,822

(1) The adjustments represent the implementation effects upon adoption of SFAS FSP No. 115-2, which was codified into FASB ASC Topic 320, Investments Debt and Equity Securities. See Note 4 of Notes to Consolidated Financial Statements for additional information.

(2) The adjustments represent the inclusion of Grapevine Finance, LLC into the consolidated results upon adoption of ASU No. 2009-17, Consolidations: Improvements to Financial Reporting by Enterprises Involved with Variable Interest Entities. See Note 9 of Notes to Consolidated Financial Statements for additional information.

(3) The adjustment represents the cumulative effect of a change in accounting principle in the methodology used to calculate the Company s policy liabilities. See *Note 2-Change in Accounting Principle on Claim Liabilities* for discussion on the change in methodology from the modified incurred date to service date.

See accompanying notes to consolidated financial statements.

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HEALTHMARKETS, INC.

and Subsidiaries

CONSOLIDATED STATEMENTS OF CASH FLOWS

	For the Year Ended December 31,		
	2011	2010	2009
	(In thousands)		
Operating Activities			
Net income	$ 10,747	$ 50,197	$ 17,724
Adjustments to reconcile net income (loss) to cash provided by operating activities:			
Income from discontinued operations	(79)	(66)	(162)
Realized gains, net	(8,942)	(5,050)	1,623
Change in deferred income taxes	(3,815)	(2,914)	3,323
Depreciation and amortization	17,203	23,219	30,906
Amortization of prepaid monitoring fees	12,500	15,000	12,500
Equity based compensation expense	7,787	18,180	12,538
Other items, net	7,620	14,737	11,418
Changes in assets and liabilities:			
Investment income due and accrued	1,717	1,720	169
Reinsurance recoverable ceded policy liabilities	104	(1,938)	23,496
Other receivables	10,270	(4,395)	8,173
Deferred acquisition costs	14,925	31,650	7,812
Prepaid monitoring fees	(12,500)	(15,000)	(12,500)
Change in current income tax payable	3,853	14,436	(7,702)
Policy liabilities	(31,181)	(147,017)	(111,724)
Other liabilities, accounts payable and accrued expenses	(7,890)	(26,130)	(11,850)
Cash provided by (used in) continuing operations	22,319	(33,371)	(14,256)
Cash used in discontinued operations	(9)	(112)	(296)
Net cash provided by (used in) operating activities	22,310	(33,483)	(14,552)
Investing Activities			
Securities available for sale			
Purchases	(8,632)	(38,078)	(70,407)
Sales	161,997	138,777	92,043
Maturities, calls and redemptions	104,237	83,318	92,089
Student loan receivables	8,084	8,640	8,791
Short-term and other investments, net	(254,004)	(1,033)	(161,305)
Purchases of property and equipment	(7,156)	(9,542)	(10,076)
Net cash (out flow) proceeds from acquisition and disposition of subsidiaries		(45)	(440)
Change in restricted cash	(1,277)	(1,337)	(766)
Decrease (increase) in agent receivables	(3,788)	(9,480)	433
Net cash provided by/(used in) investing activities	(539)	171,220	(49,638)
Financing Activities			
Repayment of student loan credit facility	(8,600)	(8,700)	(8,700)
Change in cash overdraft.	(159)	(6,804)	9,571
Increase in investment products	(1,414)	(4,514)	(4,794)
Excess tax benefits from equity-based compensation	(793)	(1,123)	(1,673)
Proceeds from shares issued to agent plans and other	4,294	7,044	8,005
Purchases of treasury stock	(10,597)	(9,718)	(21,152)
Dividends paid to shareholders		(118,454)	
Other financing activity	(77)		
Net cash used in financing activities	(17,346)	(142,269)	(18,743)

Net change in cash and cash equivalents	4,425	(4,532)	(82,933)
Cash and cash equivalents at beginning of period	12,874	17,406	100,339
Cash and cash equivalents at end of period in continuing operations	$ 17,299	$ 12,874	$ 17,406
Supplemental disclosures of cash flow information:			
Interest paid (exclusive of the student loan credit facility)	$ 18,511	$ 27,594	$ 31,445
Interest paid under the student loan credit facility	$	$	$ 985
Federal income taxes paid, net of refunds	$ 8,841	$ 21,532	$ 21,009

See accompanying notes to consolidated financial statements.

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HEALTHMARKETS, INC.

and Subsidiaries

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. ORGANIZATION AND BASIS OF PRESENTATION

ORGANIZATION

The consolidated financial statements include the accounts of HealthMarkets, Inc. and its subsidiaries, which are collectively referred to as the *Company* or *HealthMarkets.* HealthMarkets, Inc. is a holding company, the principal asset of which is its investment in its wholly owned subsidiary, HealthMarkets, LLC. HealthMarkets, LLC s principal assets are its investments in its separate operating subsidiaries, including its regulated insurance subsidiaries and Insphere Insurance Solutions, Inc. (Insphere) (see Note 20 of Notes to Consolidated Financial Statements for condensed financial information of HealthMarkets, LLC).

HealthMarkets conducts its insurance businesses through its indirect wholly owned insurance company subsidiaries, The MEGA Life and Health Insurance Company (MEGA), Mid-West National Life Insurance Company of Tennessee (Mid-West), The Chesapeake Life Insurance Company (Chesapeake) and HealthMarkets Insurance Company (HMIC). MEGA is an insurance company domiciled in Oklahoma and is licensed to issue health, life and annuity insurance policies in the District of Columbia and 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, the District of Columbia 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 the District of Columbia and all states except New Jersey, New York and Vermont. HMIC is an insurance company domiciled in Oklahoma and is licensed to issue health and life insurance policies in the District of Columbia and all states except New York and New Hampshire.

A group of private equity investors, including affiliates of The Blackstone Group, Goldman Sachs Capital Partners and Credit Suisse-DLJ Merchant Banking Partners (the Private Equity Investors) in the aggregate own approximately 86.9% of the Company s outstanding shares. See Note 15 of Notes to Consolidated Financial Statements.

Business Segments

The Company operates four business segments: Commercial Health Division, Insphere, Corporate and Disposed Operations. Through the Company s Commercial Health Division the Company underwrites and administers a broad range of health and supplemental insurance products. Insphere includes net commission revenue, agent incentives, marketing costs and costs associated with the creation and development of Insphere. Corporate includes investment income not allocated to the other segments, realized gains or losses, interest expense on corporate debt, the Company s student loan business, general expenses relating to corporate operations and operations that do not constitute reportable operating segments. Disposed Operations includes the remaining run out of the Medicare Division and the Other Insurance Division, as well as the residual operations from the disposition of other businesses prior to 2009. (See Note 19 of Notes to Consolidated Financial Statements for financial information regarding our segments).

Nature of Operations

Through the Company s Commercial Health Division, HealthMarkets insurance company subsidiaries administer and issue primarily health insurance policies covering individuals, families, the self-employed and small businesses. HealthMarkets plans are designed to accommodate individual needs and include basic hospital-medical expense plans, plans with preferred provider organizations (PPO) features, catastrophic hospital expense plans, as well as other supplemental types of coverage. Historically, the Company marketed

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HEALTHMARKETS, INC.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

these products to the self-employed and individual markets through independent agents contracted with its insurance company subsidiaries. In the third quarter of 2010, the Company discontinued marketing its health benefit plans in all but a limited number of states in which Insphere, a subsidiary, does not currently have access to third-party health insurance products. The Company will continue to focus its efforts on selling products underwritten by third-party carriers as well as marketing its own supplemental insurance products.

During 2009, the Company formed Insphere, a Delaware corporation and a wholly owned subsidiary of HealthMarkets, LLC. Insphere is a distribution company specializing in the distribution to the small business and middle-income markets. Insphere distributes life, health, long-term care and retirement insurance to these markets through a portfolio of products from nationally recognized insurance carriers. Insphere is an authorized agency in all 50 states and the District of Columbia. Insphere maintains marketing agreements for the distribution of health benefits plans with a number of non-affiliated insurance carriers as well as the Company s own insurance subsidiaries. The non-affiliated carriers include, among others, United Healthcare s Golden Rule Insurance Company, Humana and Aetna, for which Insphere distributes individual health insurance products. Additionally, Insphere distributes certain Medicare Advantage products for Humana and United Healthcare. Insphere also distributes supplemental insurance, life and annuity, long-term care and retirement insurance products for a variety of non-affiliated insurance carriers as well as the Company s own insurance subsidiaries.

Concentrations

Insphere maintains marketing agreements for the distribution of health benefits plans with a number of non-affiliated insurance carriers as well as the Company s own insurance subsidiaries. The products offered by the third-party carriers and the Company s insurance subsidiaries offer coverage and benefit variations that may fit one consumer better than another. In the markets where Insphere distributes these third-party carrier products, these products have, to a great extent, replaced the sale of the Company s own health benefit plans. During 2011, approximately 48% of the revenue recorded in Commissions and other income was generated through four third-party carriers.

Additionally, during the 2011, the Company s insurance subsidiaries generated approximately 56% of premium revenue from new and existing business from the following 10 states:

	Percentage
California	14%
Texas	7%
Maine	7%
Florida	6%
Washington	5%
Massachusetts	4%
Illinois	4%
North Carolina	3%
Pennsylvania	3%
Georgia	3%
	56%

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HEALTHMARKETS, INC.

and Subsidiaries

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS (Continued)

BASIS OF PRESENTATION

The consolidated financial statements have been prepared on the basis of accounting principles generally accepted in the United States of America (GAAP). The more significant variances between GAAP and statutory accounting practices prescribed or permitted by regulatory authorities for insurance companies are:

- fixed maturities classified as available for sale are carried at fair value under GAAP, rather than generally at amortized cost;
- the deferral of new business acquisition costs under GAAP, rather than expensing them as incurred;
- the determination of the liability for future policyholder benefits based on realistic assumptions under GAAP, rather than on statutory rates for mortality and interest;
- the recording of reinsurance receivables as assets under GAAP rather than as reductions of liabilities; and
- the exclusion of non-admitted assets for statutory purposes.

See Note 12 of Notes to Consolidated Financial Statements for net income and statutory surplus from insurance company subsidiaries as determined using statutory accounting practices. All significant intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates

Preparation of the financial statements in accordance with GAAP requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. These estimates are based on management s knowledge of current events and actions that the Company may take in the future. As such, actual results may differ from these estimates. The Company believes its critical accounting policies affect its more significant judgments and estimates used in the preparation of its consolidated financial statements. These critical accounting policies are as follows:

- the valuations of certain assets and liabilities require fair value estimates;
- the recognition of premium revenue;
- the recognition of commission revenue;

the estimate of claim liabilities;