PENN TREATY AMERICAN CORP
Form 10-K
April 02, 2002

SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-K

[X] Annual Report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 For the fiscal year ended December 31, 2001

or

[ ] Transition Report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the transition period from _____ to _____

Commission file number 0-13972

PENN TREATY AMERICAN CORPORATION
3440 Lehigh Street, Allentown, PA 18103
(610) 965-2222

Incorporated in Pennsylvania I.R.S. Employer ID No. 23-1664166

Securities registered pursuant to Section 12(b) of the Act:
Common Stock, $.10 par value

Securities registered pursuant to Section 12(g) of the Act: None
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. YES [X] NO [ ]

Indicate by check mark 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. [X]

The aggregate market value of the voting stock held by non-affiliates of the registrant as of March 18, 2002 was $106,909,908.

The number of shares outstanding on the Registrant's common stock, par value $.10 per share, as of March 18, 2002 was 19,367,737.

Documents Incorporated By Reference:
(1) Proxy Statement for the 2001 Annual Meeting of Shareholders - Part III (2) Other documents incorporated by reference on this report are listed in the Exhibit Index

PART I

Item 1. Business

(a) Penn Treaty American Corporation

We are a leading provider of long-term care insurance in the United States. We market our products primarily to older persons in the states in which we are licensed through independent insurance agents. Our principal products are individual, defined benefit accident and health insurance policies covering long-term skilled, intermediate and custodial nursing home and home health care. Our policies are designed to make the administration of claims simple, quick and sensitive to the needs of our policyholders. We also own insurance agencies that sell senior-market insurance products underwritten by other insurers and us.

We are among the largest writers of individual long-term care insurance in terms of annualized premiums. We sold 26,474 long-term care policies in 2001, representing $47 million of annualized premiums. At December 31, 2001, we had 242,644 long-term care insurance policies in-force, representing $351 million of annualized premiums. Our total premiums were $350 million in 2001, representing a compound annual growth rate of 22.7% from $102.4 million in 1995. We market our products primarily through the independent agency channel, which we believe to be effective in distributing long-term care insurance.

We introduced our first long-term nursing home insurance product in 1972 and our first home health care insurance product in 1983, and we have developed a record of innovation in long-term care insurance products. Since 1994, we have introduced several new products designed to meet the changing needs of our customers, including the following:

- The Independent Living policy, which provides coverage over the full term of the policy for home care services furnished by unlicensed homemakers or companions, as well as licensed care providers;

- The Personal Freedom policy, which provides comprehensive coverage for nursing home and home health care;

- The Assisted Living policy, which is a nursing home plan that provides enhanced benefits and includes a home health care rider; and

- The Secured Risk Nursing Facility and Post Acute Recovery policies, which provide limited benefits to higher risk insureds.

In addition, available policy riders include an automatic annual benefit increase, benefits for adult day-care centers and a return of premium benefit.

Although nursing home and home health care policies accounted for 95.3% of our total annualized premiums in-force as of December 31, 2001, we also market and sell life, disability, Medicare supplement, other hospital care insurance products and a group plan, which offers long-term care coverage to groups on a guaranteed issue basis.

Effective December 31, 2001, we entered a reinsurance transaction to reinsure, on a quota share basis, substantially all of our respective long-term care insurance policies then in-force. The agreement was entered with Centre Solutions (Bermuda) Limited, which is rated A- by A.M. Best. The agreement, which is subject to certain coverage limitations, meets the requirements to qualify as reinsurance for statutory accounting, but not for generally accepted accounting principles. The initial premium of the treaties is approximately $619,000,000, comprised of $563,000,000 of debt and equity securities transferred subsequent to December 31, 2001, and $56,000,000 held as funds due to the reinsurer. The initial premium and future cash flows from the reinsured policies, less claims payments, ceding commissions and risk charges, will be credited to a notional experience account, which is held for our benefit in the

event of commutation and recapture on or after December 31, 2007. The notional experience account balance will receive an investment credit based upon the total return of a series of benchmark indices and hedges, which are designed to closely match the duration of our reserve liabilities.

The Long-Term Care Insurance Industry

The long-term care insurance market has grown rapidly in recent years. According to studies by Conning & Co. and LifePlans, Inc., the long-term care insurance market experienced a compound average growth rate of 20.1% from 1994 to 1999, rising from approximately $1.7 billion of net written premiums in 1994 to approximately $4.2 billion of net written premiums in 1999. We expect this growth to continue based on the projected demographics of the United States population, the rising costs of health care and a regulatory environment that supports the use of private long-term care insurance.

The population of senior citizens (over age 65) in the U.S. is projected to grow from the current estimated level of approximately 35 million to approximately 70 million by 2030, according to a 1996 U.S. Census Bureau report. Furthermore, health and medical technologies are improving life expectancy and, by extension, increasing the number of people requiring some form of long-term care. According to a 1999 report by Conning & Co., market penetration of long-term care insurance products in the over-65 age group ranges from 5% to 7%. The size of the target population and the lack of penetration of the existing market indicate a substantial growth opportunity for companies providing long-term care insurance products.

We believe that the rising cost of nursing home and home health care services makes long-term care insurance an attractive means to pay for these services. According to a 1998 report by the U.S. Healthcare Financing Administration, the combined cost of home health care and nursing home care was $20.0 billion in 1980. By 1996, this cost had risen to $108.7 billion. In addition, recent and proposed tax legislation encourages individuals to use private insurance for long-term care needs through tax incentives at both the federal and state levels.

Our Strategy

We seek to enhance shareholder value by strengthening our position as a leader in providing long-term care insurance. We intend to accomplish this goal through the following strategies:

Recommencing sales in all states. During 2001, we ceased new sales in the majority of states in which we are licensed to sell new insurance policies. This action resulted from a concern that our statutory surplus would continue to decline from new sales during a period in which we were formulating our Corrective Action Plan with the Pennsylvania Insurance Department. Since our Corrective Action Plan was approved in February 2002, we have recommenced sales in 26 states. We are actively working with all states in order to recommence sales in all jurisdictions. See "Management's Discussion and Analysis - Liquidity and Capital Resources."

Refinancing our long-term debt. We have $74,750,000 of convertible debt that matures in December 2003. We do not expect that our debt will be converted into shares of common stock at that time. Therefore, we intend to seek refinancing alternatives that will extend the maturity of the debt and provide favorable terms to our shareholders.

Developing and qualifying new products with state insurance regulatory

authorities. We have sold long-term care insurance for over 29 years. As an innovator in nursing home and home health care insurance, we have introduced many new policies over the years, including four new products in the last five years. By continually discussing long-term care needs with our agency force and policyholders, we are able to design new products and to offer what we believe to be the most complete benefit features in the industry. The development of new products enables us to generate new business, maintain proper pricing levels and provide advancements in the benefits we offer. We intend to continue to develop new insurance products designed to meet the needs of senior citizens and their families.

Increasing the size and productivity of our network of independent agents. We have significantly increased the number of agents who sell products for us and have focused our efforts on states that have larger concentrations of older individuals. We have successfully increased our number of licensed agents from approximately 13,000 in 1995 to approximately 49,000 at December 31, 2001. We intend to continue to recruit agents and we believe that we will be able to continue to expand our business. Approximately one-third of our agents write new business for us each year.

Utilizing Internet strategies. We have developed a proprietary agent sales system for long-term care insurance, LTCWorks!, which enables agents to sell products utilizing downloadable software. We believe that LTCWorks! increases the potential distribution of our products by enhancing agents' ability to present the products, assist policyholders in the application process and submit applications over the Internet. LTCWorks! provides agents who specialize in the regular sale of long-term care insurance products with a unique and easy to use sales tool and enables agents who are less familiar with long-term care insurance to present it when they are discussing other products such as life insurance or annuities.

Developing third-party administration contracts. We believe that our surplus and parent company liquidity can be supplemented by providing administrative services to other long-term care providers and self-funded plans. We believe that our experience in long-term care affords us opportunities to develop these relationships.

Introducing group products. In 2000, we began actively marketing our new group policy, which we anticipate will generate additional premium revenue from a younger policyholder base. Group products allow us to penetrate an additional market for the sale of long-term care insurance. We pursue large and small groups, and offer supplemental coverage on an individually underwritten basis to group members and their families. We currently market our group products primarily through agents who market products to individuals. However, we are in the process of developing a network of agents who generally sell other group products, and who often have existing relationships with employer groups, to market our group products. As of December 31, 2001, premiums in-force for our group products were approximately $4.0 million, covering 3,256 individuals. We believe our group products present an opportunity to significantly increase the number of policies in-force without paying significantly increased commissions.

Risk Factors

Certain statements made by us, in this filing, may be considered forward-looking within the meaning of the Private Securities Litigation Reform Act of 1995. Although we believe that our expectations are based on reasonable assumptions within the bounds of our knowledge of our business and operations, there can be no assurance that our actual results of operations will not differ materially from our expectations. Factors which could cause actual results to

differ from expectations include:

We may be unable to service and repay our debt obligations if our subsidiaries cannot pay sufficient dividends or make other cash payments to us and we may be unable to refinance our debt on favorable terms as necessary.

We are an insurance holding company whose assets principally consist of the capital stock of our operating subsidiaries. Our ability to redeem, repurchase or make interest payments on our outstanding debt is dependent upon the ability of our subsidiaries to pay cash dividends or make other cash payments to us. Our insurance subsidiaries are subject to state laws and regulations and an order of the Pennsylvania Insurance Department, which restrict their ability to pay dividends and make other payments to us. We cannot assure you that we will be able to service and repay our debt obligations through their maturity in December 2003. We do not expect our subsidiaries to have sufficient dividend capability to enable us to repay our 6.25% Convertible Subordinated Notes of $74,750,000 due December 2003. If these notes are not converted into common stock, we will have to refinance them. We cannot assure you that we will be able to refinance the notes on favorable terms.

We could suffer a loss if our premium rates are not adequate and we may be required to refund or reduce premiums if our premium rates are determined to be too high.

We set our premiums based on facts and circumstances known at the time and on assumptions about numerous variables, including the actuarial probability of a policyholder incurring a claim, the severity and duration of the claim and the mortality rate of our policyholder base, the persistency or renewal of our policies in-force and the interest rate which we expect to earn on the investment of premiums. In setting premiums, we consider historical claims information, industry statistics and other factors. If our actual experience proves to be less favorable than we assumed and we are unable to raise our premium rates, our net income may decrease. We generally cannot raise our premiums in any state unless we first obtain the approval of the insurance regulator in that state. We have filed and are preparing to file rate increases on the majority of our products. We cannot assure you that we will be able to obtain approval for premium rate increases from existing requests or requests filed in the future. If we are unable to raise our premium rates because we fail to obtain approval for a rate increase in one or more states, our net income may decrease.

If we are successful in obtaining regulatory approval to raise premium rates, the increased premiums may reduce our sales and cause policyholders to let their policies lapse. Increased lapsation would reduce our premium income and would require us to expense fully the deferred policy costs relating to lapsed policies in the period in which those policies lapse, reducing our net income in that period. Our reinsurance coverage may also be reduced if we fail to obtain required rate increases.

Insurance regulators also require us to maintain certain minimum statutory loss ratios on the policies that we sell. We must pay out, on average, a certain minimum percentage of premiums as benefits to policyholders. State regulations also mandate the manner in which insurance companies may compute loss ratios and the manner in which compliance is measured and enforced. If our policies are not in compliance with state mandated minimum loss ratios, state regulators may require us to reduce or refund premiums.

Our reserves for future policy benefits and claims may be inadequate, requiring us to increase liabilities and resulting in reduced net income and book value.

We calculate and maintain reserves for the estimated future payment of claims to our policyholders using the same actuarial assumptions that we use to set our premiums. Establishing reserves is an uncertain process, and we cannot assure you that actual claims expense will not materially exceed our reserves and have a material adverse effect on our results of operations and financial condition. Our net income depends significantly upon the extent to which our actual claims experience is consistent with the assumptions we used in setting our reserves and pricing our policies. If our assumptions with respect to future claims are incorrect, and our reserves are insufficient to cover our actual losses and expenses, we would suffer an increase in liabilities resulting in reduced net income.

Claims experience can differ from our expectations due to numerous factors, including mortality rates, duration of care and type of care utilized. Due to the inherent uncertainty in establishing reserves, it has been necessary in the past for us to increase the estimated future liabilities reflected in our reserves for claims and policy expenses. In 1999, we added approximately $4.1 million to our claim reserves for 1998 and prior claim incurrals, in 2000, we added approximately $6.6 million to our claim reserves for 1999 and prior claim incurrals, and in 2001, we added approximately $8.8 million to our claim reserves for 2000 and prior claim incurrals. Our additions to prior year incurrals in 2001 resulted from a continuance study performed by our consulting actuary. We also increased claim reserves in 2001 by $1.6 million as a result of utilizing a lower interest rate for the purpose of discounting our future liabilities. Over time, it may continue to be necessary for us to increase our reserves.

New insurance products, such as our Independent Living, Assisted Living and Personal Freedom policies, entail a greater risk of unanticipated claims than products which have more extensive historical claims data, such as long-term nursing home care insurance. We believe that individuals may be more inclined to use home health care than nursing home care, which is generally only considered after all other possibilities have been exhausted. Accordingly, we believe that home health care policies entail a greater risk of wide variations in claims experience than nursing home insurance. Because we have relatively limited claims experience with these products, we may incur higher than expected losses and expenses and may be required to adjust our reserve levels with respect to these products.

We may recognize a disproportionate amount of policy costs in one financial reporting period if our estimates with respect to the duration of our policies are inaccurate.

We recognize policy costs over the life of each policy we sell. These costs include all expenses that are directly related to, and vary with, the acquisition of the policy, including commission, underwriting and other policy issue expenses. We use the same actuarial assumptions used to compute premiums and reserves to determine the period over which to amortize policy costs.

Upon the occurrence of an unanticipated termination of a policy, we must fully expense deferred acquisition costs associated with the terminated policy. If actual experience adversely differs from our actuarial assumptions or if policies are terminated early by the insured or by us, we would recognize a disproportionate amount of policy expenses at one time, which would negatively affect our net income for that period.

Annually, we determine if the future profitability of current in-force policies is sufficient to support our remaining deferred acquisition cost

amount. This determination may include assumptions regarding the current need and future implementation of premium rate increases. We believe that we need certain rate increases in order to generate sufficient profitability to offset our current deferred acquisition costs. In the event that profits are considered insufficient to fully support the deferred acquisition costs, or if we are unable to obtain anticipated premium rate increases, we would impair the value of our deferred acquisition expense asset and would recognize a disproportionate amount of policy expenses at one time, which would negatively affect our net income for that period.

We may not be able to compete successfully with insurers who have greater financial resources or higher financial strength ratings.

We sell our products in highly competitive markets. We compete with large national insurers, smaller regional insurers and specialty insurers. Many insurers are larger and have greater resources and higher financial strength ratings than we do. In addition, we are subject to competition from insurers with broader product lines. We also may be subject, from time to time, to new competition resulting from changes in Medicare benefits, as well as from additional private insurance carriers introducing products similar to those offered by us. Also, the removal of regulatory barriers (including as a result of the Gramm-Leach-Bliley Financial Services Modernization Act of 1999) might result in new competitors entering the long-term care insurance business. These new competitors may include diversified financial services companies that have greater financial resources than we do and that have other competitive advantages, such as large customer bases and extensive branch networks for distribution.

We may suffer reduced income if governmental authorities change the regulations applicable to the insurance industry.

We are licensed to do business as an insurance company in a number of states and are subject to comprehensive regulation by the insurance regulatory authorities of those states. The primary purpose of such regulation is to protect policyholders, not shareholders. The laws of the various states establish insurance departments with broad powers with respect to such things as licensing companies to transact business, licensing agents, prescribing accounting principles and practices, admitting statutory assets, mandating certain insurance benefits, regulating premium rates, approving policy forms, regulating unfair trade, market conduct and claims practices, establishing statutory reserve requirements and solvency standards, limiting dividends, restricting certain transactions between affiliates and regulating the types, amounts and statutory valuation of investments.

State insurance regulators and the National Association of Insurance Commissioners ("NAIC") continually reexamine existing laws and regulations, and may impose changes in the future that materially adversely affect our business, results of operations and financial condition. In particular, rate rollback legislation and legislation to control premiums, policy terminations and other policy terms may affect the amount we may charge for insurance premiums. In addition, some state legislatures have discussed and implemented proposals to limit rate increases on long-term care insurance products. Because insurance premiums are our primary source of income, our net income may be negatively affected by any of these changes. Many states are now disallowing coverage exclusions incurred as a result of war or terrorist acts. We have proactively removed these exclusions in some states, but cannot be certain that our financial results would not be adversely affected by such acts.

Proposals currently pending in the U.S. Congress may affect our income. These include the implementation of minimum consumer protection standards for inclusion in all long-term care policies, including: guaranteed premium rates; protection against inflation; limitations on waiting periods for pre-existing

conditions; setting standards for sales practices for long-term care insurance; and guaranteed consumer access to information about insurers, including lapse and replacement rates for policies and the percentage of claims denied. Enactment of any of these proposals could adversely affect our net income. In addition, recent federal financial services legislation requires states to adopt laws for the protection of consumer privacy. Compliance with various existing and pending privacy requirements also could result in significant additional costs to us.

We may not be able to compete successfully if we cannot recruit and retain insurance agents.

We distribute our products principally through independent agents whom we recruit and train to market and sell our products. We also engage marketing general agents from time to time to recruit independent agents and develop networks of agents in various states. We compete vigorously with other insurance companies for productive independent agents, primarily on the basis of our financial position, support services, compensation and product features. We may not be able to continue to attract and retain independent agents to sell our products, especially if we are unable to restore our capital and surplus and improve our financial strength ratings. Our business and ability to compete would suffer if we are unable to recruit and retain insurance agents and if we lose the services provided by our marketing agents.

Our business is concentrated in a few states.

Historically, our business has been concentrated in a few states. Over the past four fiscal years, approximately half of our premiums were from sales of policies in California, Florida and Pennsylvania. Increased competition, changes in economic conditions, legislation or regulations, rating agency downgrades, statutory surplus deficiencies or the loss of our ability to write business due to regulatory intervention in any of these states could significantly affect our results of operations or prospects. In 2001, we voluntarily ceased new sales in these states as a result of our subsidiary's statutory surplus position. We recommenced sales in Pennsylvania in February 2002 and petitioned Florida and California for reentry. Until the necessary approvals are received, we are unable to sell new policies in these states. As a result of not selling policies in these states, or if we fail to recommence sales in other states, our financial condition may be materially adversely affected.

Declines in the value or the yields on our investment portfolio and significant defaults in our investment portfolio may adversely affect our net income.

Income from our investment portfolio is a significant element of our overall net income. If our investments do not perform well, we would have reduced net income and could suffer a net loss. We are susceptible to changes in market rates when cash flows from maturing investments are reinvested at prevailing market rates. Accordingly, a prolonged decrease in interest rates or in equity security prices or an increase in defaults on our investments could adversely affect our net income.

Effective December 31, 2001, we entered a reinsurance agreement to reinsure, on a quota share basis, substantially all of our long-term care insurance policies in-force. The transaction resulted in the transfer of debt and equity securities of approximately $563,000,000 to the reinsurer and a funds withheld balance of $56,000,000. The agreement provides us the opportunity to commute on or, after December 31, 2007. The reinsurer will maintain a notional experience account, which reflects the initial premium paid, future premiums collected net of claims, expenses and accumulated investment earnings. The

notional experience account balance will receive an investment credit based upon the total return of a series of benchmark indices and hedges, which are designed to closely match the duration of reserve liabilities. Periodic changes in the market values of the benchmark indices and hedges will be recorded in our financial statements as investment gains or losses in the period in which they occur. As a result, we will likely experience volatility in our future financial statements.

In addition, we depend in part on income from our investment portfolio to fund our reserves for future policy claims and benefits. In establishing the level of our reserves, we make assumptions about the performance of our investments. If our investment income or the capital gains in our portfolio are lower than expected, we may have to increase our reserves, which could adversely affect our net income.

Our new reinsurance eagreement is subject to an aggregate limit of liability, which is a function of certain factors and which may be reduced as a result of our inability to obtain certain rate increases.

Our new reinsurance agreement with Centre Solutions (Bermuda) Limited, effective December 31, 2001, is subject to certain coverage limitations and aggregate limit of liability, which is a function of certain factors and which may be reduced as a result of our inability to obtain rate increases. This limit of liability is subject to certain events such as material breach of the covenants of the agreement, regulatory risk of changes in regulation or law and our inability to achieve rate increases deemed necessary by the provisions of the agreement.

All references to this reinsurance agreement or to Centre Solutions (Bermuda) Limited throughout this filing and the attached Financial Statements are intended to contain this statement of risk.

Our reinsurers may not satisfy their obligations to us.

We obtain reinsurance from unaffiliated reinsurers on most of our policies to increase the number and size of the policies we may underwrite and reduce the risk to which we are exposed. Although reinsurance makes the reinsurer liable to us to the extent the risk is transferred to the reinsurer, it does not relieve us of our liability to our policyholders. Accordingly, we bear credit risk with respect to our reinsurers. We cannot assure you that our reinsurers will pay all of our reinsurance claims or that they will pay our reinsurance claims on a timely basis.

Our Corrective Action Plan, as approved by the Pennsylvania Insurance Department, will result in a strengthening of our statutory reserves. A component of the Corrective Action Plan is a reinsurance agreement. If the reinsurer does not honor our agreement, if the limit of liability is reduced as a result of limitations and / or conditions contained in the reinsurance agreement, or if the agreement is cancelled, our statutory surplus would be materially adversely affected.

We may not commute our new reinsurance transaction on December 31, 2007 and may incur increased expenses by not commuting.

Effective December 31, 2001, we entered a reinsurance transaction with an unaffiliated reinsurer for substantially all of our long-term care insurance policies then in-force. This agreement contains commutation provisions and allows us to recapture the reserve liabilities and the current experience account balance as of December 31, 2007 or on December 31 of any year

thereafter.

If we choose not to or are unable to commute the agreement as planned, our financial results would likely suffer a materially adverse impact due to an escalation of the charges paid to the reinsurer after December 31, 2007. Additionally, our reinsurance agreement contains significant covenants and conditions that, if breached, could result in a significant loss, requiring a payment of $2.5 million per quarter from the period of the breach through December 31, 2007. Any breach of the reinsurance agreement may also result in the immediate recapture of the reinsured business, which would have a material adverse effect on our subsidiaries' statutory surplus. Management has also completed an assessment of its ability to avoid any breach through 2002 and believes that it will remain compliant. The reinsurer has been granted warrants to acquire convertible preferred stock in the event we do not commute the agreements that, if converted, would represent an additional 20 percent of the common stock then outstanding.

We may be affected by our financial strength ratings due to highly competitive markets.

Our ability to expand and to attract new business is affected by the financial strength ratings assigned to our insurance company subsidiaries by A.M. Best Company, Inc. and Standard & Poor's Insurance Rating Services, two independent insurance industry rating agencies. A.M. Best's ratings for the industry range from "A++ (superior)" to "F (in liquidation)." Standard & Poor's ratings range from "AAA (extremely strong)" to "CC (extremely weak)." Some companies are unrated. A.M. Best and Standard & Poor's insurance company ratings are based upon factors of concern to policyholders and insurance agents and are not directed toward the protection of investors. Our subsidiaries that are rated have A.M. Best ratings of "B- (fair)" and Standard & Poor's ratings of "B- (weak)."

Certain distributors will not sell our group products unless we have a financial strength rating of at least an "A-." The inability of our subsidiaries to obtain higher A.M. Best or Standard & Poor's ratings could adversely affect the sales of our products if customers favor policies of competitors with better ratings. In addition, the recent downgrades and further downgrades in our ratings may cause our policyholders to allow their existing policies to lapse. Increased lapsation would reduce our premium income and would also cause us to expense fully the deferred policy costs relating to lapsed policies in the period in which those policies lapsed, thereby reducing our capital and surplus. Downgrades to our ratings may also lead some independent agents to sell fewer of our products or to cease selling our policies altogether.

We may not have enough capital and surplus to continue to grow.

Our continued growth is dependent upon our ability to continue to fund expansion of our markets and our network of agents while at the same time maintaining required minimum statutory levels of capital and surplus to support such growth. Our new business growth typically results in net losses on a statutory basis during the early years of a policy, due primarily to differences in accounting practices between statutory accounting principles and generally accepted accounting principles. The resultant reduction in statutory surplus, or surplus strain, can limit our ability to generate new business due to statutory restrictions on premium to surplus ratios and required statutory surplus parameters. 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 generate additional premium from new business growth, which would

result in lower net income under generally accepted accounting principles, or, in the event that our statutory surplus is not sufficient to meet minimum state premium to surplus and risk based capital ratios, we could be prohibited from generating additional premium revenue.

Furthermore, the insurance industry may undergo change in the future and, accordingly, new products and methods of service may also be introduced. In order to keep pace with any new developments, we may need to expend significant capital to offer new products and to train our agents and employees to sell and administer these products and services. We may also need to make significant capital expenditures for computer systems and other technology needed to market and administer our policies. We may not be successful in developing new products and we may not have the funds necessary to make capital expenditures. Any significant capital expenditures, or the failure to make necessary investments, may have a material adverse effect on us.

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

We are regularly involved in litigation, both as a defendant and as a plaintiff. The litigation naming us as a defendant ordinarily involves our activities as an insurer. In recent years, many insurance companies have been named as defendants in class actions relating to market conduct or sales practices, and other long-term care insurance companies have been sued when they sought to implement premium rate increases. We cannot assure you that we will not be named as a defendant in a similar case. Current and future litigation may result in financial losses, harm our reputation and require the dedication of significant management resources.

The Company and certain of its key executive officers are defendants in consolidated actions that were instituted on April 17, 2001 in the United States District Court for the Eastern District of Pennsylvania by shareholders of the Company, on their own behalf and on behalf of a putative class of similarly situated shareholders who purchased shares of the Company's common stock between July 23, 2000 through and including March 29, 2001. The consolidated amended class action complaint seeks damages in an unspecified amount for losses allegedly incurred as a result of misstatements and omissions allegedly contained in the Company's periodic reports filed with the SEC, certain press releases issued by them, and in other statements made by its officials. The alleged misstatements and omissions relate, among other matters, to the statutory capital and surplus position of the Company's largest subsidiary, Penn Treaty Network America Insurance Company. On December 7, 2001, the defendants filed a motion to dismiss the complaint, which is currently pending. The Company believes that the complaint is without merit, and it and its executives will continue to vigorously defend the matter.

We are dependent upon key personnel and our operations could be affected by the loss of their services.

Our success largely depends upon the efforts of our senior operating management, including our chairman, chief executive officer, president and founder, Irving Levit. The loss of the services of Mr. Levit or one or more of our key personnel could have a material adverse effect on our operations.

Our principal shareholder and other members of our senior management team have the ability to exert significant influence over our affairs.

Mr. Levit is our principal shareholder and controls, directly or indirectly, approximately 13% of our common stock. In addition, a majority of the members of our board of directors are members of our senior management team. Accordingly, Mr. Levit and other members of our senior management team have the power to exert significant influence over our policies and affairs.

Certain anti-takeover provisions in state law and our Articles of Incorporation may make it more difficult to acquire us and thus may depress the market price of our common stock.

Our Restated and Amended Articles of Incorporation, the Pennsylvania Business Corporation Law of 1988, as amended, and the insurance laws of states in which our insurance subsidiaries do business contain certain provisions which could delay or impede the removal of incumbent directors and could make a merger, tender offer or proxy contest involving us difficult, even if such a transaction would be beneficial to the interests of our shareholders, or discourage a third party from attempting to acquire control of us. In particular, the classification of our board of directors could have the effect of delaying a change in control. In addition, we have authorized 5,000,000 shares of preferred stock, which we could issue without further shareholder approval and upon such terms and conditions, and having such rights privileges and preferences, as the board of directors may determine. We have no current plans to issue any preferred stock. Insurance laws and regulations of Pennsylvania and New York prohibit any person from acquiring control of us, and thus indirect control of our insurance subsidiaries, without the prior approval of the insurance commissioners of those states.

Reduced liquidity and price volatility could result in a loss to investors.

Although our common stock is listed on the New York Stock Exchange, there can be no assurance as to the liquidity of investments in our common stock or as to the price investors may realize upon the sale of our common stock. These prices are determined in the marketplace and may be influenced by many factors, including the liquidity of the market for the common stock, the market price of the common stock, investor perception and general economic and market conditions.

Corporate Background

We are registered and approved as a holding company under the Pennsylvania Insurance Code. We were incorporated in Pennsylvania on May 13, 1965 under the name Greater Keystone Investors, Inc. and changed our name to Penn Treaty American Corporation on March 25, 1987. Penn Treaty Life Insurance Company ("Penn Treaty Life") was incorporated in Pennsylvania under the name Family Security Life Insurance Company on June 6, 1962, and its name was changed to Quaker State Life Insurance Company on December 29, 1969, at which time it was operating under a limited insurance company charter. We acquired Quaker State Life Insurance Company on May 4, 1976, and changed its name to Penn Treaty Life Insurance Company. On July 13, 1989, Penn Treaty Life acquired all of the outstanding capital stock of AMICARE Insurance Company (formerly Fidelity Interstate Life Insurance Company), a stock insurance company organized and existing under the laws of Pennsylvania, and changed its name to Network America Life Insurance Company on August 1, 1989.

On August 30, 1996, we consummated the acquisition of all of the issued and outstanding capital stock of Health Insurance of Vermont, Inc., and have since changed its name to American Network Insurance Company.

Senior Financial Consultants Company, an insurance agency that we own, was incorporated in Pennsylvania on February 23, 1988 under the name Penn Treaty Service Company. On February 29, 1988, it acquired, among other assets, the rights to renewal commissions on a certain block of Penn Treaty Life's existing in-force policies from Cher-Britt Agency, Inc., and an option to purchase the rights to renewal commissions on a certain block of Penn Treaty Life's existing

policies from Cher-Britt Insurance Agency, Inc., an affiliated company of Cher-Britt Agency, Inc. In connection with this acquisition, on March 3, 1988, we changed the name of the Agency to Cher-Britt Service Company. The option was exercised on March 3, 1989. Its name was changed to Senior Financial Consultants Company on August 9, 1994.

On December 31, 1997, Penn Treaty Life dividended to us its common stock ownership of Penn Treaty Network America Insurance Company. At that time, Penn Treaty Network America Insurance Company assumed substantially all of the assets, liabilities and premium in-force of Penn Treaty Life through a purchase and assumption reinsurance agreement. On December 30, 1998, we sold our common stock interest in Penn Treaty Life to an unaffiliated insurer. All remaining policies in-force were assumed by Penn Treaty Network America Insurance Company through a 100% quota share agreement.

On November 25, 1998, we entered into a purchase agreement to acquire all of the common stock of United Insurance Group Agency, Inc. ("United Insurance Group"), a Michigan based consortium of long-term care insurance agencies. The acquisition was effective January 1, 1999.

On December 10, 1999, we incorporated Penn Treaty (Bermuda), Ltd., a Bermuda based reinsurer, for the purpose of reinsuring affiliated long-term insurance contracts at a future date.

On January 1, 2000, we acquired Network Insurance Senior Health Division ("NISHD"), a Florida-based insurance agency brokerage company. NISHD was purchased by Penn Treaty Network America Insurance Company.

(b) Insurance Products

Since 1972, we have developed, marketed and underwritten defined benefit accident and health insurance policies designed to be responsive to changes in:

- the characteristics and needs of the senior citizen market;
- governmental regulations and governmental benefits available for senior citizens; and
- the health care and long-term care industries in general.

As of December 31, 2001, 95.3% of our total annualized premiums in-force were derived from long-term care policies, which include nursing home and home health care policies. Our other lines of insurance include life, disability, Medicare supplement and other hospital care policies and riders. We solicit input from both our independent agents and our policyholders with respect to the changing needs of insureds. In addition, our representatives regularly attend seminars to monitor significant trends in the industry.

Our focus on long-term care has enabled us to gain expertise in claims and underwriting which we have applied to product development. Through the years, we have continued to build on our brand names by offering the independent agency channel a series of differentiated products. We have expanded our product line to offer both tax-qualified and non-qualified plans based on consumer demand for both.

The following table sets forth, for each of our last three fiscal years our annualized gross premiums by type of policy.

	(annualized premiums in $000's Year ended December 31,				
	2001		2000		1
Long-term facility, home and comprehensive coverage:					
Annualized premiums	$ 351,268	95.3%	$ 360,600	95.2%	$
Number of policies	242,644		242,075		
Average premium per policy	$ 1,448		$ 1,490		
Disability insurance:					
Annualized premiums	$ 6,415	1.7%	$ 6,634	1.8%	
Number of policies	13,226		13,502		
Average premium per policy	$ 485		$ 491		
Medicare supplement:					
Annualized premiums	$ 8,449	2.3%	$ 7,314	1.9%	
Number of policies	8,216		7,696		
Average premium per policy	$ 1,028		$ 950		
Life insurance:					
Annualized premiums	$ 2,185	0.6%	$ 3,785	1.0%	
Number of policies	3,763		6,315		
Average premium per policy	$ 581		$ 599		
Other insurance:					
Annualized premiums	$ 398	0.1%	$ 609	0.2%	
Number of policies	2,459		3,900		
Average premium per policy	$ 162		$ 156		
Total annualized premiums in force	$ 368,715	100%	$ 378,942	100%	$
Total Policies	270,308		273,488		

We received an insurance license in 1972, which permitted us to write insurance in 12 states. In 1974, we filed a long-term care policy offering a five-year benefit period. Our policy was the first national plan to equally cover all levels of care, including skilled, intermediate and custodial care, with an extended benefit period. We began the sale of home health care riders, which pay for licensed nurses, certified nurses' aides and home health care workers who provide care/assistance in the policyholder's home, in 1983. This plan was the first in the industry to include a limited benefit for homemaker companion care provided by a friend, neighbor, relative or religious organization. We began the use of table-based underwriting, which enables higher risk policyholders to receive coverage at a risk-adjusted premium level, in 1986. Appropriate risk is calculated based upon medical conditions and ability to perform daily activities. Multiple rate classes enabled us to penetrate an untapped market in long-term care insurance sales.

We specialize in the sale of long-term care insurance, which is generally defined as nursing home and home health care insurance coverage.

Long-Term Nursing Home Care. Our long-term nursing home care policies generally provide a fixed or maximum daily benefit payable during periods of nursing home confinement prescribed by a physician or necessitated by the policyholder's cognitive impairment or inability to perform two or more activities of daily living. These policies include built-in benefits for alternative plans of care, waivers of premiums after 90 days of benefit payments

on a claim and unlimited restoration of the policy's maximum benefit period. All levels of nursing care, including skilled, intermediate and custodial (assisted living) care, are covered and benefits continue even when the policyholder's required level of care changes. Skilled nursing care refers to professional nursing care provided by a medical professional (a doctor or registered or licensed practical nurse) located at a licensed facility that cannot be provided by a non-medical professional. Assisted living care generally refers to non-medical care, which does not require professional treatment and can be provided by a non-medical professional with minimal or no training. Intermediate nursing care is designed to cover situations that would otherwise fall between skilled and assisted living care and includes situations in which an individual may require skilled assistance on a sporadic basis.

Our current long-term nursing home care policies provide benefits that are payable over periods ranging from one to five years, or the lifetime of the policyholder. These policies provide for a maximum daily benefit on costs incurred ranging from $60 to $300 per day. Our Personal Freedom policies also provide comprehensive coverage for nursing home and home health care, offering benefit "pools of coverage" ranging from $75,000 to $300,000, as well as lifetime coverage.

Long-Term Home Health Care. Our home health care policies generally provide a benefit payable on an expense-incurred basis during periods of home care prescribed by a physician or necessitated by the policyholder's cognitive impairment or inability to perform two or more activities of daily living. These policies cover the services of registered nurses, licensed practical nurses, home health aides, physical therapists, speech therapists, medical social workers and other similar home health practitioners. Benefits for our currently marketed home health care policies are payable over periods ranging from six months to five years, or the lifetime of the policyholder, and provide from $40 to $160 per day of home benefits. Our home health care policies also include built-in benefits for waivers of premiums after 90 days of benefit payments, and unlimited restoration of the policy's maximum benefit period.

We currently offer the following products:

Independent Living Plan. The Independent Living Plan (offered since 1994) was our first stand-alone home health care plan that covered all levels of care received at home. Besides covering skilled care and care by home health aides, this plan pays for care provided by unlicensed, unskilled homemakers. This care includes assistance with cooking, shopping, housekeeping, laundry, correspondence, using the telephone and paying bills. Historically, only limited coverage had been provided under certain of our home health care policies for homemaker care, typically for a period of up to 30 days per calendar year during the term of the policy. This benefit is now standard in most long-term care policies. Family members also may be reimbursed for any training costs incurred in order to provide in-home care.

The Independent Living policy provides that we will waive the elimination period, the time at the beginning of the period during which care is provided for which no benefits are available under the policy (usually twenty days), if the insured agrees to utilize a care management service referred by us. Newer policies offer up to 100% of the daily benefit if a care management service is used, versus 80% if the policyholder does not elect care management services. We engage the care manager at the time a claim is submitted to prepare a written assessment of the insured's condition and to establish a written plan of care. We have subsequently incorporated the use of care management in all of our new home health care policies.

Personal Freedom Plan. Our Personal Freedom Plan (offered since 1996) is a comprehensive plan which provides a sum of money for long-term care to be used for either nursing facility or home health care. The plan also provides coverage for homemaker care for insureds who are unable to perform activities of daily living such as cooking, shopping, housekeeping, laundry, correspondence, using the telephone, paying bills and managing medication.

When policyholders purchase this policy, with benefits ranging from $75,000 to $300,000, as well as lifetime coverage, they may then access up to the face amount of the policy for nursing home or home health care as needed, subject to maximum daily limits. This plan also includes an optional return of premium/nonforfeiture benefit.

Assisted Living Plan. The Assisted Living Plan (offered since 1996) is a stand-alone facility care plan that provides benefits in either a traditional nursing home setting or in an Assisted Living Facility, the setting preferred by the majority of policyholders. This policy, coupled with an optional home health care rider, offers benefits similar to those of the Personal Freedom Plan, but on an elapsed time, cost incurred basis with a maximum daily benefit, cost incurred basis, rather than a sum of money basis.

Secured Risk Plan. Our Secured Risk Plan (offered since 1998) offers facility care benefits to people who would most likely not qualify for long-term care insurance under traditional policies. Table-based underwriting allows us to examine these substandard conditions by level of activity and independence of the applicant. This plan offers protection to such individuals by providing coverage for care in a nursing facility or in the insured's home if he or she chooses the limited optional home health care benefits. Features of this plan, as with many of our other plans, include coverage for pre-existing conditions after six months, guaranteed renewal for life, premiums that will not increase with age and no requirement of prior hospitalization.

Post Acute Recovery Plan. The Post Acute Recovery Plan (offered since 1999) provides facility and home health care benefits for up to one year after traditional medical insurance, Medicare, Medigap or HMO services stop, thereby providing a more affordable short-term plan. Coupled with optional home health care benefits, this product pays for medical recovery in a facility or in the insured's home when traditional health care coverage stops. Features of this plan include immediate coverage (no elimination period or deductible), coverage for pre-existing conditions after six months in most states, guaranteed renewal and premiums that will not increase with age. We offer a "Care Solutions" service with this plan, in which a care manager works with the insured to design a plan of care suited to meet his or her individual needs.

Group Long-Term Care Insurance Plan. Our group long-term care insurance plan (offered since 2000) provides group long-term care insurance to groups formed for purposes other than the purchase of insurance, such as an employee group, an association or a professional organization. A group master policy is issued to the group and all participating members are issued certificates of insurance, which describe the benefits available under the policy. Eligibility for insurance is guaranteed to all members of the group without an underwriting review on an individual basis. Group members, spouses and parents can generally purchase supplemental coverage beyond the level paid by the group. This coverage is offered on an individually underwritten basis.

We are currently seeking to expand our group insurance business and are enhancing our marketing efforts towards this end. Our management considers this area to offer significant opportunities for sales growth.

Riders. Our policies generally offer an optional lifetime inflation rider, which provides for a 5% increase of the selected daily benefit amount on each anniversary date for the lifetime of the policy. An optional nonforfeiture

shortened benefit rider, which provides the insured with the right to maintain a portion of his or her benefit period in the event the policy lapses after being continuously in-force for at least three years, is also available. The return of premium benefit rider provides for a pro-rata return of premium in the event of death or surrender beginning in the sixth year. We also offer and encourage the purchase of home health care riders to supplement our nursing home policies and nursing home riders to supplement our home health care policies.

Previously, we offered numerous other riders to supplement our long-term care policies. The need, however, for many of these riders has been eliminated due to the incorporation of many of the benefits they provided into the basic coverage included in our newest long-term care policies. Among the built-in benefits provided under the long-term care policies we currently market are hospice care, adult day care, survivorship benefits and restoration of benefits.

After the enactment of the Health Insurance Portability and Accountability Act of 1996, issues arose relating to the tax status of long-term care benefits included as part of non-qualified plans. To permit policyholders to purchase either the tax-qualified plan or non-qualified plan that best suits their needs, we introduced the Pledge and Promise. The Pledge and Promise states that, if the U.S. Congress or the Treasury Department should determine that the benefits received on a long-term care policy are considered taxable income, we will allow a policyholder to convert the policy to a tax-qualified policy at any time. The Pledge and Promise further states that, if the U.S. Congress or Treasury Department should determine that the benefits received on a non-qualified plan will not be considered taxable income, we will allow a policyholder to convert the policy from a tax-qualified plan to a non-qualified plan at any time prior to its first anniversary.

(c) Marketing

Markets. The following chart shows premium revenues by state for each of the states where we do business:

		($000)			
	Year	Year Ended December 31,			Current Year %
State	Entered	2001	2000	1999	of Total
Arizona	1988	$15,392	$15,677	$13,715	4.4%
California	1992	51,498	50,165	43,514	14.7%
Colorado	1969	4,701	3,564	2,563	1.3%
Florida	1987	65,067	71,588	63,218	18.6%
Georgia	1990	5,066	4,764	3,350	1.4%
Illinois	1990	19,525	19,748	15,970	5.6%
Iowa	1990	5,361	5,097	4,317	1.5%
Maryland	1987	3,948	3,896	3,427	1.1%
Michigan	1989	6,654	6,357	5,469	1.9%
Missouri	1990	4,061	4,391	4,297	1.2%
Nebraska	1990	4,263	4,358	3,952	1.2%
New Jersey	1996	8,374	7,856	4,707	2.4%
New York	1998	4,103	2,665	676	1.2%
North Carolina	1990	10,399	9,690	8,089	3.0%
Ohio	1989	11,880	11,935	10,149	3.4%
Pennsylvania	1972	43,126	48,692	37,661	12.3%

Texas	1990	17,847	16,105	11,879	5.1%
Virginia	1989	22,638	22,370	19,597	6.5%
Washington	1993	10,670	9,814	7,485	3.0%
All Other States (1)		35,818	38,381	28,481	10.2%
All States		$350,391	$357,113	$292,516	100.0%

(1) Includes all states in which premiums comprised less than one percent of total premiums in 2001.

Our goal is to strengthen our position as a leader in providing long-term care insurance to senior citizens by underwriting, marketing and selling our products throughout the United States. We focus our marketing efforts primarily in those states where we have successfully developed networks of agents and that have the highest concentration of individuals whose financial status and insurance needs are compatible with our products.

Agents. We market our products principally through independent agents. With the exception of agents employed by our insurance agency subsidiaries, we do not directly employ agents but instead rely on relationships with independent agents and their sub-agents. We provide assistance to our agents through seminars, underwriting training and field representatives who consult with agents on underwriting matters, assist agents in research and accompany agents on marketing visits to current and prospective policyholders.

Each independent agent must be authorized by contract to sell our products in each state in which the agent and our companies are licensed. Some of our independent agents are large general agencies with many sales-persons (sub-agents), while others are individuals operating as sole proprietors. Some independent agents sell multiple lines of insurance, while others concentrate primarily or exclusively on accident and health insurance. We do not have exclusive agency agreements with any of our independent agents and they are free to sell policies of other insurance companies, including our competitors.

We generally do not impose production quotas or assign exclusive territories to agents. The amount of insurance written for us by individual independent agents varies. We periodically review and terminate our agency relationships with non-producing or under-producing independent agents and agents who do not comply with our guidelines and policies with respect to the sale of our products.

We are actively engaged in recruiting and training new agents. Sub-agents are recruited by the independent agents and are licensed by us with the appropriate state regulatory authorities to sell our policies. Independent agents are generally paid higher commissions than those employed directly by insurance companies, in part to account for the expenses of operating as an independent agent. We believe that the commissions we pay to independent agents are competitive with the commissions paid by other insurance companies selling similar policies. The independent agent's right to renewal commissions is vested and commissions are paid as long as the policy remains in-force, provided the agent continues to abide by the terms of the contract. We generally permit many of our established independent agents to collect the initial premium with the application and remit such premium to us less the commission. New independent agents are required to remit the full amount of initial premium with the application. We provide assistance to our independent agents in connection with

the processing of paperwork and other administrative services.

We have developed a proprietary agent sales system for long-term care insurance, LTCWorks!, which enables agents to sell products utilizing downloadable software. We believe that LTCWorks! increases the potential distribution of our products by enhancing agents' ability to present the products, assist policyholders in the application process and submit applications over the Internet. LTCWorks! provides agents who specialize in the regular sale of long-term care insurance products with a unique and easy to use sales tool and enables agents who are less familiar with long-term care insurance to present it when they are discussing other products such as life insurance or annuities.

Marketing General Agents and General Agents. We selectively utilize marketing general agents for the purpose of recruiting independent agents and developing networks of agents in various states. Marketing general agents receive an override commission on business written in return for recruiting, training and motivating the independent agents. In addition, marketing general agents may function as general agents for us in various states. No single grouping of agents accounted for more than 10% of our new premiums or renewal premiums written in 2001 or 2000. One agency accounted for 16% of total premiums earned in 1999. We acquired a division of this agency during 2000, which reduced our reliance on this unaffiliated agency. We have not delegated any underwriting or claims processing authority to any agents.

Group and Franchise Insurance. We have recently begun to sell group long-term care insurance to groups formed for purposes other than the purchase of insurance, such as an employee group, an association or a professional organization. A group master policy is issued to the group and all participating members are issued certificates of insurance, which describe the benefits available under the policy. Eligibility for insurance is guaranteed to all members of the group without an underwriting review on an individual basis. Group members, spouses and parents can generally purchase supplemental coverage beyond the level paid by the group. This coverage is offered on an individually underwritten basis.

We currently market our group products primarily through agents who market products to individuals. However, we are in the process of developing a network of agents who generally sell other group products, and who often have existing relationships with employer groups, to market our group products. As of December 31, 2001, premiums in-force for our group products were approximately $4.0 million, covering 3,256 individuals. We believe our group products present an opportunity to significantly increase the number of policies in-force without paying significantly increased commissions.

From time to time, we also sell franchise insurance, which is a series of individually underwritten policies sold to an association or group. While franchise insurance is generally presented to groups that endorse the insurance, policies are issued to individual group members. Each application is underwritten and issuance of policies is not guaranteed to members of the franchise group.

(d) Administration

Underwriting

We believe that the underwriting process through which we, as an accident and health insurance company particularly in the long-term care segment, choose to accept or reject an applicant for insurance is critical to our success. We

have offered long-term care insurance products for nearly 30 years and we believe we have benefited significantly from our longstanding focus on this specialized line. Through our experience with and focus on this niche product, we have been able to establish a system of underwriting designed to permit us to process our new business and assess the risk presented effectively and efficiently.

Applicants for insurance must complete detailed medical questionnaires. Physical examinations are not required for our accident and health insurance policies, but medical records are frequently requested. All long-term care applications are reviewed by our in-house underwriting department and all applicants are also interviewed by members of our underwriting department via telephone. This "personal history interview" is aimed at not only confirming the information disclosed on the application, but also at gaining more insight into the applicant's physical abilities, activity level and cognitive functioning. We consider age, cognitive status and medical history, among other factors, in deciding whether to accept an application for coverage and, if accepted, the appropriate rate class for the applicant. With respect to medical history, efforts are made to underwrite on the basis of the medical information listed on the application, but an Attending Physician's Statement is often requested. We also frequently use face-to-face assessments conducted in the applicant's home by independent subcontractors (nurse networks). This evaluation is similar to the personal history interview in terms of obtaining medical information and information regarding the applicant's functional abilities, and it includes an expanded cognitive test. We also use the Minnesota Cognitive Acuity Screening test (formerly known as Cognistat) when a question of cognitive functioning exists and is not adequately addressed by the other underwriting tools, or when the possibility of cognitive problems is identified by one of the other underwriting tools. In addition to age, cognitive status and medical history, our underwriters are concerned with the applicant's abilities to perform the activities of daily living. Our underwriting process extends beyond current conditions, however, and takes into account how existing health conditions are likely to progress and to what degree the independence of the applicant is likely to change as the applicant ages.

We use table-based underwriting, or multiple rate classifications, as a means to accept more business while obtaining the appropriate premiums for additional risk. Applicants are placed in different risk classes for acceptance and premium calculation based on medical conditions and level of activity during the application process. We currently offer Premier, Select, Standard and Secured risk classifications. If we determine that we cannot offer the requested coverage, we may suggest an alternative product suitable for coverage for higher risk applicants. Accepted policies are usually issued within seven working days from receipt of the information necessary to underwrite the application.

Pre-existing conditions disclosed on an application for new long-term nursing home care and most home health care policies are covered immediately upon approval of the policy. Undisclosed pre-existing conditions are covered after six months in most states and two years in certain other states. In addition, our Independent Living policies immediately cover all disclosed pre-existing conditions. In the case of individual Medicare supplement policies, pre-existing conditions are generally not covered during the six-month period following the effective date of the policy.

In group long-term care insurance, eligibility is guaranteed to all members of the group without an underwriting review on an individual basis. However, supplemental coverage offered to group members and their parents and spouses is individually underwritten. Franchise insurance is a series of individually underwritten policies sold to the members of an association or group. The issuance of policies is not guaranteed to individual members of the franchise group.

In conjunction with the development of our LTCWorks! system, we developed an underwriting credit-scoring system, which provides consistent underwriting and rate classification for applicants with similar medical histories and conditions.

Claims

Claims for policy benefits, except with respect to Medicare supplement and disability claims, are processed by our claims department, which includes nurses employed or retained as consultants. We use third party administrators to process our Medicare supplement claims due to the large number of claims and the small benefit amount typically paid for each claim. Beginning in 1999, we also engaged a third party administrator to perform all administration, including claims processing, for our disability business.

For nursing home claims, upon notification of a claim, a personal claims assistant is assigned to review all necessary documentation, including verification of the facility where the claimant resides. A claims examiner verifies eligibility of the claim under the policy. Every effort is made to facilitate the processing of the claim, recognizing that this service efficiency provides substantial value to the policyholder and his or her family. Toward this end, the personal claims assistant verifies the continued residence of the policyholder in the facility each month and expedites payment of the claim.

We periodically utilize the services of "care managers" to review certain claims, particularly those filed under home health care policies. When a claim is filed, we may engage a care manager to review the claim, including the specific health problem of the insured and the nature and extent of health care services being provided. This review may include visiting the claimant to assess his or her condition. The care manager assists the insured and us by ensuring that the services provided to the insured, and the corresponding benefits paid, are appropriate under the circumstances. The care manager then follows the claimant's progress with periodic contact to ensure that the plan of care continues to be appropriate and that it is adjusted if warranted by improvement in the claimant's condition.

Home care claims require the greatest amount of diligent overview and we have utilized care management techniques for nearly ten years. Under the terms of our Independent Living policy, we will waive the elimination period if the insured agrees to utilize a care manager. Newer policies offer 100% claims coverage if the claimant uses a care manager and provide up to 80% of the daily benefit if care manager services are not used. The majority of all of our home health care claims in 2001 were submitted to care management. We anticipate that this usage will continue as our business grows.

In 1999, we created and staffed an in-house care management unit. This in-house unit conducts the full range of care management services, which were previously provided exclusively by subcontractors. We intend to continue to develop this unit, as we believe it can meet many of our care management needs more effectively and less expensively than third party vendors can.

Systems Operations

We maintain our own computer system for most aspects of our operations, including policy issuance, billing, claims processing, commission reports, premium production by agent (state and product) and general ledger. Critical to our ongoing success is our ability to continue to provide the quality of service for which we are known to our policyholders and agents. We believe that our overall systems are an integral component in delivering that service. If we are

able to generate additional statutory capital, we intend to significantly expand or enhance our existing system through a replacement project. The extent of the project has not been determined, but we estimate that it would require a substantial investment of funds and resources to replace our entire system. One current proposal would cost approximately $4 million to $8 million over three years.

In 2000, we entered an outsourcing agreement with a computer services vendor, which thereby assumed responsibility for the majority of the daily operations of our system, future program development and business continuity planning. This vendor provides both in-house and external servicing of all existing legacy systems and hardware. We believe that this vendor can provide better expertise in the evolving arena of information technology than we can provide by running our own operations.

(e) Premiums

Our long-term care policies provide for guaranteed renewability at then current premium rates at the option of the insured. The insured may elect to pay premiums on a monthly, quarterly, semi-annual or annual basis. In addition, we offer an automatic payment feature that allows policyholders to have premiums automatically withdrawn from a checking account.

Premium rates for all lines of insurance are subject to state regulation. Premium regulations vary greatly among jurisdictions and lines of insurance. Rates for our insurance policies are established with the assistance of our independent actuarial consultants and reviewed by the insurance regulatory authorities. Before a rate change can be made, the proposed change must be filed with and, with respect to rates for individual policies, approved by the insurance regulatory authorities in each state in which an increase is sought. Regulators may not approve the increases we request, may approve them only with respect to certain types of policies or may approve increases that are smaller than those we request.

As a result of minimum statutory loss ratio standards imposed to state regulations, the premiums on our accident and health polices are subject to reduction and/or corrective measures in the event insurance regulatory agencies in states where we do business determine that our loss ratios either have not reached or will not reach required minimum levels. See "Government Regulation."

(f) Future Policy Benefits and Claims Reserves

We are required to maintain reserves equal to our probable ultimate liability for claims and related claims expenses with respect to all policies in-force. Reserves, which are computed with the assistance of an independent firm of actuarial consultants, are established for:

- claims which have been reported but not yet paid;
- claims which have been incurred but not yet reported; and
- the discounted present value of all future policy benefits less the discounted present value of expected future premiums.

The amount of reserves relating to reported and unreported claims incurred is determined by periodically evaluating historical claims experience and statistical information with respect to the probable number and nature of such claims. We compare actual experience with estimates and adjust reserves on the basis of such comparisons.

In addition to reserves for incurred claims, reserves are also established for future policy benefits. The policy reserves represent the discounted present value of future obligations that are likely to arise from the policies that we underwrite, less the discounted present value of expected future premiums on such policies. The reserve component is determined using generally accepted actuarial assumptions and methods. However, the adequacy of these reserves rests on the validity of the underlying assumptions that were used to price the products; the more important of these assumptions relate to policy lapses, loss ratios and claim incidence rates. We review the adequacy of our deferred acquisition costs and reserves on an annual basis, utilizing assumptions for future expected claims and interest rates. If we determine that future gross profits of our in-force policies are not sufficient to recover our deferred acquisition costs, we recognize a premium deficiency and "unlock" or change our original assumptions and reset our reserves to appropriate levels using new assumptions. The assumptions we use to calculate reserves for claims under our long-term care products are based on our 29 years of significant claims experience, primarily with respect to nursing home care products, and on the experience of the industry as a whole.

We began offering home health care coverage in 1983 and since that time have realized a significant increase in the number of home health care policies written. Claims experience with home health care coverage is more limited than the available nursing home care claims experience. Our experience with respect to the Independent Living policy, which was first offered in November 1994, and the Assisted Living and Personal Freedom policies, which were first offered in late 1996, is more limited than our experience with skilled care facilities. We believe that individuals may be more inclined to utilize home health care than nursing home care, which is generally considered only after all other possibilities have been explored. Accordingly, we believe that wide variations in claims experience may be more likely in home health care insurance than in nursing home insurance. Our actuarial consultants utilize both our experience and other industry data in the computation of reserves for the home health care product line.

In addition, newer long-term care products, developed as a result of regulation or market conditions, may incorporate more benefits with fewer limitations or restrictions. For instance, the Omnibus Budget Reconciliation Act of 1990 required that Medicare supplement policies provide for guaranteed renewability and waivers of pre-existing condition coverage limitations under certain circumstances. In addition, the NAIC has recently adopted model long-term care policy language providing nonforfeiture benefits and a rate stabilization standard for long-term care policies, either or both of which may be adopted by the states in which we write policies. The fluidity in market and regulatory forces may limit our ability to rely on historical claims experience for the development of new premium rates and reserve allocations. See "Government Regulation."

We use an independent firm of actuarial consultants and an in-house actuary to assist us in pricing insurance products and establishing reserves with respect to those products. Additionally, actuaries assist us in improving the documentation of our reserve methodology and in determining the adequacy of our reserves and their underlying assumptions, a process that has resulted in certain adjustments to our reserve levels. See "Management's Discussion and Analysis of Financial Condition and Results of Operations--Overview." Although we believe that our reserves are adequate to cover all policy liabilities, we cannot assure you that reserves are adequate or that future claims experience will be similar to, or accurately predicted by, our past or current claims experience.

As of December 31, 2001 and 2000, our reserves for current claims were $214,466,000 and $164,565,000, respectively. In 2001, we added approximately $8.8 million to our claim reserves for 2000 and prior claim incurrals, and in 2000 we added approximately $6.6 million to our claim reserves for 1999 and prior claim incurrals. Our additions to prior year incurrals in 2001 resulted from a continuance study performed by our consulting actuary. We also increased reserves in 2001 by $1.6 million as a result of utilizing a lower interest rate for the purpose of discounting our future liabilities. Over time, it may continue to be necessary for us to increase our claim reserves.

Policy reserves have been computed principally by the net level premium method based upon estimated future investment yield, mortality, morbidity, withdrawals, premium rate increases and other benefits. The following table sets forth the composition of our policy reserves at December 31, 2001 and 2000 and the assumptions pertinent thereto:

	Amount of Policy Reserves as of December 31,	
	2001	2000
Accident and health	$ 382,660	$ 348,344
Annuities and other	131	118
Ordinary life, individual	13,255	12,947

	Years of Issue	Discount Rate	Discount Rate
Accident and health	1976 to 1986	6.5%	7.0%
	1987	6.5%	7.5%
	1988 to 1991	6.5%	8.0%
	1992 to 1995	6.5%	6.0%
	1996	6.5%	7.0%
	1997 to 2000	6.5%	6.8%
	2001	6.5%	6.5%
Annuities and other	1977 to 1983	6.5% & 7.0%	6.5% & 7.0%
Ordinary life, individual	1962 to 2001	3.0% to 5.5%	3.0% to 5.5%

Basis of Assumption

Accident and health.....Morbidity and withdrawals based on actual and projected experience.
Annuities and other.....Primarily funds on deposit inclusive of accrued interest.
Ordinary life, individual.....Mortality based on 1955-60 Intercompany Mortality Table Combined Select and Ultimate.

In 2001, the anticipated future gross profits of our in-force long-term care business was not sufficient to recover our deferred acquisition costs, resulting in the recognition of an impairment charge. In connection with this, we unlocked our prior reserve assumptions due to our determination that certain elements were insufficient to produce adequate future coverage of claims. These assumptions include interest rates, premium rates, shock lapses and anti-selection of policyholder persistence.

(g) Reinsurance

As is common in the insurance industry, we purchase reinsurance to increase the number and size of the policies we may underwrite. Reinsurance is purchased

by insurance companies to insure their liability under policies written to their insureds. By transferring, or ceding, certain amounts of premium (and the risk associated with that premium) to reinsurers, we can limit our exposure to risk. However, if a reinsurance company becomes insolvent or otherwise fails to honor its obligations under any reinsurance agreements, we would remain fully liable to the policyholder.

We reinsure any life insurance policy to the extent the risk on that policy exceeds $50,000. We currently reinsure our ordinary life policies through Reassurance Company of Hanover. We also have a reinsurance agreement with Transamerica Occidental Life Insurance Company to reinsure term life policies whose risk exceeds $15,000, and with Employer's Reassurance Corporation to reinsure credit life policies whose risk exceeds $15,000.

We have ceded, through a fronting arrangement, 100% of certain whole life and deferred annuity policies to Provident Indemnity Life Insurance Company. No new policies have been ceded under this arrangement since December 31, 1995. We also entered into a reinsurance agreement to cede 100% of certain life, accident, health and Medicare supplement insurance policies to Life and Health of America. These fronting arrangements are used when one insurer wishes to take advantage of another insurer's ability to procure and issue policies. As the fronting company, we remain ultimately liable to the policyholder, even though all of our risk is reinsured. Therefore, the agreements require the maintenance of securities in escrow for our benefit in the amount equal to our statutory reserve credit.

We have also entered into a reinsurance agreement with Cologne Life Reinsurance Company with respect to home health care policies with benefit periods exceeding 36 months. No new policies have been reinsured under this agreement since 1998.

We also enter into funds withheld financial reinsurance treaties, which allow us to temporarily increase statutory surplus. Although these treaties qualify for statutory accounting treatment as reinsurance, we believe that the agreements do not qualify as reinsurance according to generally accepted accounting principles. We commuted all existing financial reinsurance treaties, effective December 31, 2001, which reduced statutory surplus by approximately $20,000,000. At December 31, 2001 and 2000, our statutory surplus was increased by $0 and approximately $20,000,000, respectively, from financial reinsurance.

We have stop-loss reinsurance on our disability business that limits our liability in aggregate for the life of the policy or above monthly loss amounts. This coverage is ceded to Employer's Reassurance Corporation, Reassurance America Life Insurance Company and Lincoln National Life Insurance Company. Since January 1, 2000, no new policies have been ceded to Employer's Reassurance Corporation, which has historically provided the majority of our stop-loss reinsurance.

In 2001, we ceded substantially all of our disability policies to Assurity Life Insurance Company on a 100% quota share basis. The reinsurer may assume ownership of the policies as a sale upon various state and policyholder approvals. We received a ceding allowance of approximately $5,000,000 and ceded reserves to the reinsurer of approximately $10,300,000.

Effective December 31, 2001, we entered a reinsurance transaction to reinsure, on a quota share basis, substantially all of our respective long-term care insurance policies then in-force. The agreement was entered with Centre Solutions (Bermuda) Limited, which is rated A- by A.M. Best. The agreement is subject to certain coverage limitations, including an aggregate limit of

liability, which is a function of certain factors and which may be reduce in the event that the rate increases that the reinsurance agreement may require are not obtained. The agreement meets the requirements to qualify as reinsurance for statutory accounting, but not for generally accepted accounting principles. The initial premium of the treaties is approximately $619,000,000, comprised of $563,000,000 of cash and qualified securities transferred subsequent to December 31, 2001, and $56,000,000 held as funds due to the reinsurer. The initial premium and future cash flows from the reinsured policies, less claims payments, ceding commissions and risk charges, will be credited to a notional experience account, which is held for our benefit in the event of commutation and recapture on or after December 31, 2007. The notional experience account balance will receive an investment credit based upon the total return of a series of benchmark indices and hedges, which are designed to closely match the duration of our reserve liabilities.

Pennsylvania insurance regulations require that funds ceded for reinsurance provided by a foreign or "unauthorized" reinsurer must be secured by funds held in a trust account or by a letter of credit for the protection of policyholders. We received approximately $648,000,000 in statutory reserve credits from this transaction as of December 31, 2001, of which $619,000,000 was held by us and $29,000,000 was backed by letters of credit, which increased our statutory surplus by $29,000,000 as well.

The agreements contain commutation provisions and allow us to recapture the reserve liabilities and the current experience account balance as of December 31, 2007 or on December 31 of any year thereafter. We intend to commute the treaty on December 31, 2007; therefore, we are accounting for the agreements in anticipation of this commutation. In the event we do not commute the agreements on December 31, 2007, we will be subject to escalating expenses.

The following table shows our historical use of reinsurance, excluding financial reinsurance:

Company	A.M. Best Rating	Reinsurance R December 31, 2001 (in thou
General and Cologne Life Re of America	A+	$10,365
Assurity Life Insurance Company	A-	8,403
Provident Indemnity Life Insurance Company	NR3	4,362
Lincoln National Life Insurance Company (1)	A	999
Employer's Reassurance Corporation (1)	A++	510
Reassure America Life Insurance Company (1)	A++	426
Life and Health of America	B-	388
Transamerica Occidental Life Insurance Company	A+	30
Reassurance Company of Hanover	A	15
Swiss Reassurance Life and Health America	A++	7

(1) We determine the amount of reinsurance recoverable in accordance with GAAP on an aggregate basis for multiple companies that provide reinsurance on our disability business. In order to segregate the risk by reinsurer, we have listed the amount reported for Reassure America Life Insurance Company and Lincoln National Life Insurance Company for reserve credits as calculated under statutory accounting principles as of December 31, 2001 and 2000. The amounts reported for

Employer's Reassurance Corporation include the net differences between statutory and GAAP reporting for our disability reinsurance.

(h) Investments

Management has categorized the majority of our investment securities as available for sale since they may be sold in response to changes in interest rates, prepayments and similar factors. Investments in this category are reported at their current market value with net unrealized gains and losses, net of the applicable deferred income tax effect, being added to or deducted from the Company's total shareholders' equity on the balance sheet. As of December 31, 2001, shareholders' equity was increased by $10,583,000 due to unrealized gains of $16,032,000 in the investment portfolio. As of December 31, 2000, shareholders' equity was decreased by $662,000 due to unrealized losses of $1,005,000 in the investment portfolio.

In 2001, we classified our convertible bond portfolio as trading account investments. Changes in trading account investment market values are recorded in our statement of operations during the period in which the change occurs, rather than as an unrealized gain or loss recorded directly through equity. We recorded a trading account loss in 2001 of $3,428,000, which reflects the unrealized and realized loss of our convertible portfolio that arose during the year ended December 31, 2001. At December 31, 2001, we had liquidated our entire trading portfolio.

We invest in securities and other investments authorized by applicable state laws and regulations and follow an investment policy designed to maximize yield to the extent consistent with liquidity requirements and preservation of assets. We generally purchase fixed income securities with the expectation of holding them until maturity. However, we classify these securities as available for sale and have sold securities prior to their stated maturity, at either a gain or loss.

We attempt to match the duration and cash flows of our investments to the liquidity requirements of our liabilities. Although we have generally met our cash flow requirements from operations, we expect that asset / liability management will become increasingly important as future claims payments increase.

Our investments are managed by three external firms: Davidson Capital Management of Wayne, Pennsylvania, First Union National Bank of Charlotte, North Carolina and Palisade Capital Management of Fort Lee, New Jersey.

Our investments, other than convertible securities (which were classified as trading), are recorded at their current market value, with any unrealized gains or losses recorded through shareholders' equity in the current reporting period. The following table sets forth the mix of our investment portfolio and the market value by investment segment for the periods ended December 31, 2001 and 2000.

	December 31, 2001		De
Amortized Cost	Estimated Market Value	Amortized Cost	
	(amounts in thousands)		

U.S. Treasury securities and obligations of U.S. Government authorities and agencies	$ 164,712	$ 172,063	$ 120,691
Obligations of states and political sub-divisions	572	612	572
Mortgage backed securities	42,587	43,331	26,529
Debt securities issued by foreign governments	11,954	12,089	15,817
Corporate securities	243,793	250,513	186,268
Equities	8,760	9,802	17,112
Policy Loans	181	181	142
Total Investments	$ 472,559	$ 488,591	$ 367,13
Net unrealized gain (loss)	16,032		(1,005
	$ 488,591		$ 366,126

As of December 31, 2001, 98% of our total investments were fixed income debt securities, 40% of which were securities of the United States Government (or its agencies or instrumentalities). The balance of our total investment portfolio consisted substantially of publicly traded equity securities.

The following table shows the composition of the debt securities investment portfolio (at carrying value), excluding short-term investments, by rating as of December 31, 2001. Ratings are prepared by Moody's Debt Rating Service or Standard & Poor's Rating Services.

Rating	Amount	Percent
	(in thousands)	
U.S. Treasury and U.S. Agency Securities.....	$192,024	40.1%
Aaa or AAA.....	34,282	7.2%
Aa or AA.....	75,782	15.8%
A.....	128,852	26.9%
BBB.....	34,383	7.2%
Other or Not Rated.....	13,285	2.8%
Total.....	$478,608	100.0%

Our investment policy is to purchase U.S. Treasury securities, U.S. agency securities and investment-grade municipal and corporate securities with the highest yield to maturity available, and to have 7% to 10% of our bond investment portfolio mature each year. Our policy also limits high-yield investments (those rated below "BBB-") to 5% percent of our total portfolio. We may only purchase bonds rated "B" or higher. Certain investments may be unrated

or in the process of being rated. At December 31, 2001, our investment portfolio contained no direct investments in real estate.

During 2001, we recognized impairment losses of approximately $5,800,000, which we deemed to be other than temporary. During 2000, we recognized impairment losses of approximately $3,200,000. These losses have been recorded as realized losses in the consolidated income statement.

We have historically limited our investments in equity securities. At December 31, 2001, we held common and preferred stock investments that represented 2% of our total investments. We intend to limit our common and preferred stock investments to 10% or less of our total investments.

The following table sets forth, for the periods indicated, certain information concerning investment income, including dividend payments made on common and preferred stock. The average yield calculation does not reflect the impact upon market value of investments due to changes in market interest rates.

	Year Ended December 31,		
	2001	2000	1999
	(in thousands, except percentages)		
Average balance of investments, cash and cash equivalents during the period, at cost (1)	$545,404	$441,300	$392,592
Net investment income	30,613	27,408	22,619
Average yield on investments	5.6%	6.2%	5.8%

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(1) Average of average quarterly balances for all investable assets, including bonds, equity securities, policy loans and cash; average quarterly balances are averages of amounts at the beginning and end of the quarter.

At December 31, 2001, the duration of our bond portfolio was approximately 5.0 years. The following table sets forth the contractual maturity of our bond portfolio, at amortized cost, by aggregate amount and as a percentage of our bond portfolio. Actual maturities may differ from contractual maturities because of the issuer's right to call or repay obligations, with or without call or prepayment penalties.

	Amortized Cost	Estimated Market Value
Due in one year or less	$ 7,969	$ 8,054
Due after one year through five years	145,916	149,582
Due after five years through ten years	234,452	244,114
Due after ten years	75,281	76,858
	$463,618	$478,608

As of December 31, 2001, we had purchased approximately $50 million of corporate owned life insurance ("COLI") from American General Life Insurance Company of Houston, Texas in order to fund the long-term expense of our employee benefit programs. COLI is not recorded as an investment but is reported as its own financial statement category.

Effective December 31, 2001, we entered a reinsurance agreement to reinsure, on a quota share basis, substantially all of our long-term care insurance policies in-force. The transaction resulted in the transfer of approximately $563,000,000 of cash and qualified securities to the reinsurer, representing approximately 93% of our December 31, 2001 investment and cash portfolio. The reinsurer will maintain a notional experience account, which reflects the initial premium paid, future premiums collected net of claims, expenses and accumulated investment earnings. The notional experience account balance will receive an investment credit based upon the total return from a series of benchmark indices and hedges that are intended to match the duration of our reserve liability. Because we do not have controlling ownership of these assets, periodic changes in the market values of the benchmark indices and hedges will be recorded in our financial statements in the period in which they occur. The investment credit rate represents a total return on a benchmark portfolio, which subjects us to potential realized losses in our investment income. As a result, we will likely experience significant increased volatility in our future financial statements.

i) Selected Financial Information: Statutory Basis

The following table shows certain ratios derived from our insurance regulatory filings with respect to our accident and health policies presented in accordance with accounting principles prescribed or permitted by insurance regulatory authorities ("SAP"), which differ from the presentation under generally accepted accounting principles ("GAAP") and, which also differ from the presentation under SAP for purposes of demonstrating compliance with statutorily mandated loss ratios. See "Government Regulation."

	Year ended December 31,		
	2001	2000	1999
Loss Ratio (1) (4)	154.4%	67.1%	70.4%
Expense ratio (2) (4)	-201.3%	114.4%	44.1%
Combined loss and expense ratio	-46.9%	181.5%	114.5%
Persistency (3)	88.0%	86.4%	86.7%

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(1) Loss ratio is defined as incurred claims and increases in policy reserves divided by collected premiums.

(2) Expense ratio is defined as commissions and expenses incurred divided by collected premiums.

(3) Persistency represents the percentage of premiums renewed, which we calculate by dividing the total annual premiums in-force at the end of each year (less first year business for that year) by the total annual premiums in-force for the prior year. For purposes of this calculation, a decrease in total annual premiums in-force at the end of any year would be a result of non-renewal policies, including those policies that have terminated by reason of death, lapse due to nonpayment of premiums and/or conversion to other policies offered by us.

(4) The 2001, 2000 and 1999 loss ratios and expense ratios are significantly affected by the reinsurance of approximately $408,093,000, $225,741,000 and $90,230,000, respectively, in premium on a statutory basis under financial and other reinsurance treaties . reserves are accounted for as offsetting negative benefits and

negative premium, causing substantial deviation in reported ratios.

Statutory accounting practices. As long-term care insurers, our insurance subsidiaries are required by state insurance regulation to have statutory surplus, which is calculated differently than under GAAP, at a sufficient level to support existing policies as well as new business growth. Under SAP, costs associated with sales of new policies must be charged to earnings as incurred. Because these costs, together with required reserves, generally exceed first year premiums, statutory surplus may be reduced during periods of increasing first year sales. The commissions paid to agents on new business production are generally higher for new business than for renewing policies. Because statutory accounting requires commissions to be expensed as paid, rapid growth in first year business generally results in higher expense ratios.

Effective December 31, 2001, we entered a reinsurance transaction that, according to Pennsylvania insurance regulation, required the reinsurer to provide us with letters of credit in order for us to receive statutory reserve and surplus credit from the reinsurance. The letters of credit were dated subsequent to December 31, 2001, as a result of the final closing of the agreement. In addition, the initial premium paid for the reinsurance included investment securities carried at amortized cost but valued at market price for purposes of the premium transfer and the experience account. The Pennsylvania Insurance Department permitted us to receive credit of $29,000,000 for the letters of credit, and to accrue the anticipated, yet unknown, gain of $18,000,000 from the sale of securities at market value, in our statutory financial results for December 31, 2001. The impact of this permitted practice served to increase the statutory surplus of our insurance subsidiaries by approximately $47,000,000 at December 31, 2001. Had we not been granted a permitted practice, our statutory surplus would have been negative until the first quarter 2002 reporting period, when a permitted practice would no longer be required due to our receipt of the letters of credit prior to March 31, 2002.

Minimum loss ratios. Mandated loss ratios are calculated in a manner intended to provide adequate reserving for the long-term care insurance risks, using statutory lapse rates and certain assumed interest rates. The statutorily assumed interest rates differ from those used in developing reserves under GAAP. For this reason, statutory loss ratios differ from loss ratios reported under GAAP. Mandatory statutory loss ratios also differ from loss ratios reported on a current basis under SAP for purposes of our annual and quarterly state insurance filings. The states in which we are licensed have the authority to change these minimum ratios and to change the manner in which these ratios are computed and the manner in which compliance with these ratios is measured and enforced. We are unable to predict the impact of (1) the imposition of any changes in the mandatory statutory loss ratios for individual or group long-term care policies to which we may become subject, (2) any changes in the minimum loss ratios for individual or group long-term care or Medicare supplement policies, or (3) any change in the manner in which these minimums are computed or enforced in the future. We have not been informed by any state that our subsidiaries do not meet mandated minimums, and we believe we are in compliance with all such minimum ratios. In the event the we are not in compliance with minimum statutory loss ratios mandated by regulatory authorities with respect to certain policies, we may be required to reduce or refund our premiums on such policies.

(j) Insurance Industry Rating Agencies

Our subsidiaries have A.M. Best ratings of "B- (fair)" and Standard & Poor's ratings of "B- (weak)." A.M. Best and Standard & Poor's ratings are based on a comparative analysis of the financial condition and operating performance for the prior year of the companies rated, as determined by their publicly available reports. A.M. Best's classifications range from "A++ (superior)" to "F (in liquidation)." Standard & Poor's ratings range from "AAA (extremely strong)" to "CC (extremely weak)." A.M. Best and Standard & Poor's ratings are based upon

factors of concern to policyholders and insurance agents and are not directed toward the protection of investors and are not recommendations to buy, hold or sell a security. In evaluating a company's financial and operating performance, the rating agencies review profitability, leverage and liquidity, as well as book of business, the adequacy and soundness of reinsurance, the quality and estimated market value of assets, the adequacy of reserves and the experience and competence of management.

Certain distributors will not sell our group products unless we have a financial strength rating of at least an "A-." The inability of our subsidiaries to obtain higher A.M. Best or Standard & Poor's ratings could adversely affect the sales of our products if customers favor policies of competitors with better ratings. In addition, a downgrade in our ratings may cause our policyholders to allow their existing policies to lapse. Increased lapsation would reduce our premium income and would also cause us to expense fully the deferred policy costs relating to lapsed policies in the period in which those policies lapsed. Recent downgrades or further downgrades in our ratings also may lead some independent agents to sell less of our products or to cease selling our policies altogether.

(k) Competition

We operate in a highly competitive industry. We believe that competition is based on a number of factors, including service, products, premiums, commission structure, financial strength, industry ratings and name recognition. We compete with a large number of national insurers, smaller regional insurers and specialty insurers, many of whom have considerably greater financial resources, higher ratings from A.M. Best and Standard and Poor's and larger networks of agents than we do. Many insurers offer long-term care policies similar to those we offer and utilize similar marketing techniques. In addition, we are subject to competition from insurers with broader product lines. We also may be subject, from time to time, to new competition resulting from changes in Medicare benefits, as well as from additional private insurance carriers introducing products similar to those offered by us.

We also actively compete with other insurers in attracting and retaining agents to distribute our products. Competition for agents is based on quality of products, commission rates, underwriting, claims service and policyholder service. We continuously recruit and train independent agents to market and sell our products. We also engage marketing general agents from time to time to recruit independent agents and develop networks of agents in various states. Our business and ability to compete may suffer if we are unable to recruit and retain insurance agents and if we lose the services provided by our marketing general agents.

We also compete with non-insurance financial services companies such as banks, securities brokerage firms, investment advisors, mutual fund companies and other financial intermediaries marketing insurance products, annuities, mutual funds and other retirement-oriented investments. The Gramm-Leach-Bliley Financial Services Modernization Act of 1999 ("Gramm-Leach-Bliley Act") implemented fundamental changes in the regulation of the financial services industry, permitting mergers that combine commercial banks, insurers and securities firms under one holding company. The ability of banks to affiliate with insurers may adversely affect our ability to remain competitive.

The insurance industry may undergo further change in the future and, accordingly, new products and methods of service may also be introduced. In order to keep pace with any new developments, we may need to expend significant capital to offer new products and to train our agents and employees to sell and

administer these products and services. Our ability to compete with other insurers depends on our success in developing new products.

(l) Government Regulation

Insurance companies are subject to supervision and regulation in all states in which they transact business. We are registered and approved as a holding company under the Pennsylvania Insurance Code. Our insurance company subsidiaries are chartered in the states of Pennsylvania and New York. We are currently licensed in all states and the District of Columbia.

The extent of regulation of insurance companies varies, but generally derives from state statutes which delegate regulatory, supervisory and administrative authority to state insurance departments. Although many states' insurance laws and regulations are based on models developed by the National Association of Insurance Commissioners, and are therefore similar, variations among the laws and regulations of different states are common.

The NAIC is a voluntary association of all of the state insurance commissioners in the United States. The primary function of the NAIC is to develop model laws on key insurance regulatory issues that can be used as guidelines for individual states in adopting or enacting insurance legislation. While the NAIC model laws are accorded substantial deference within the insurance industry, these laws are not binding on insurance companies unless adopted by states, and variation from the model laws within states is common.

The Pennsylvania Insurance Department, the New York Insurance Department and the insurance regulators in other jurisdictions have broad administrative and enforcement powers relating to the granting, suspending and revoking of licenses to transact insurance business, the licensing of agents, the regulation of premium rates and trade practices, the content of advertising material, the form and content of insurance policies and financial statements and the nature of permitted investments. In addition, regulators have the power to require insurance companies to maintain certain deposits, capital, surplus and reserve levels calculated in accordance with prescribed statutory standards. The NAIC has developed minimum capital and surplus requirements utilizing certain risk-based factors associated with various types of assets, credit, underwriting and other business risks. This calculation, commonly referred to as RBC, serves as a benchmark for the regulation of insurance company solvency by state insurance regulators. The primary purpose of such supervision and regulation is the protection of policyholders, not investors. See "Selected Financial Information - Statutory Basis."

Most states mandate minimum benefit standards and loss ratios for long-term care insurance policies and for other accident and health insurance policies. Most states have adopted the NAIC's proposed standard minimum loss ratios of 65% for individual Medicare supplement policies and 75% for group Medicare supplement policies. A significant number of states, including Pennsylvania and Florida, also have adopted the NAIC's proposed minimum loss ratio of 60% for both individual and group long-term care insurance policies. Certain states, including New Jersey and New York, have adopted a minimum loss ratio of 65% for long-term care. The states in which we are licensed have the authority to change these minimum ratios, the manner in which these ratios are computed and the manner in which compliance with these ratios is measured and enforced.

On an annual basis, the Pennsylvania Insurance Department and the New York Insurance Department are provided with a calculation prepared by our consulting actuaries regarding compliance with required minimum loss ratios for Medicare supplement and credit policies. This report is made available to all states.

Although certain other policies (e.g., nursing home and hospital care policies) also have specific mandated loss ratio standards, there presently are no similar reporting requirements in the states in which we do business for such other policies.

In December 1986, the NAIC adopted the Long-Term Care Insurance Model Act ("Model Act"), which was adopted to promote the availability of long-term care insurance policies, to protect applicants for such insurance and to facilitate flexibility and innovation in the development of long-term care coverage. The Model Act establishes standards for long-term care insurance, including provisions relating to disclosure and performance standards for long-term care insurers, incontestability periods, nonforfeiture benefits, severability, penalties and administrative procedures. Model regulations were also developed by the NAIC to implement the Model Act. Some states have also adopted standards relating to agent compensation for long-term care insurance. In addition, from time to time, the federal government has considered adopting standards for long-term care insurance policies, but it has not enacted any such legislation to date.

Some state legislatures have adopted proposals to limit rate increases on long-term care insurance products. In the past, we have been generally successful in obtaining rate increases when necessary. We currently have rate increases on file with various state insurance departments and anticipate that increases on other products may be required in the future. If we are unable in the future to obtain rate increases, or in the event of legislation limiting rate increases, we believe it would have a negative impact on our future earnings.

In September 1996, Congress enacted the Health Insurance Portability and Accountability Act ("HIPAA"), which permits premiums paid for eligible long-term care insurance policies after December 31, 1996 to be treated as deductible medical expenses for federal income tax purposes. The deduction is limited to a specified dollar amount ranging from $200 to $2,500, with the amount of the deduction increasing with the age of the taxpayer. In order to qualify for the deduction, the insurance contract must, among other things, provide for limitations on pre-existing condition exclusions, prohibitions on excluding individuals from coverage based on health status and guaranteed renewability of health insurance coverage. Although we offer tax-deductible policies, we will continue to offer a variety of non-deductible policies as well. We have long-term care policies that qualify for tax exemption under HIPAA in all states in which we are licensed.

In 1998, the NAIC adopted the Codification of Statutory Accounting Principles ("Codification") guidance, which replaced the current Accounting Practices and Procedures manual as the NAIC's primary guidance on statutory accounting as of January 1, 2001. The Codification provides guidance for areas where statutory accounting has been silent and changes current statutory accounting in some areas, including the recognition of deferred income taxes.

The Pennsylvania and New York Insurance Departments have adopted the Codification guidance, effective January 1, 2001. The Codification guidance serves to reduce the insurance subsidiaries' surplus, primarily due to certain limitations on the recognition of goodwill and EDP equipment and the recognition of other than temporary declines in investments. In 2001, our statutory surplus was reduced by approximately $2,000 as a result of the Codification guidance. These reductions are partially offset by certain other items, including the recognition of deferred tax assets subject to certain limitations.

We are also subject to the insurance holding company laws of Pennsylvania

and of the other states in which we are licensed to do business. These laws generally require insurance holding companies and their subsidiary insurers to register and file certain reports, including information concerning their capital structure, ownership, financial condition and general business operations. Further, states often require prior regulatory approval of changes in control of an insurer and of intercompany transfers of assets within the holding company structure. The Pennsylvania Insurance Department and the New York Insurance Department must approve the purchase of more than 10% of the outstanding shares of our common stock by one or more parties acting in concert, and may subject such party or parties to the reporting requirements of the insurance laws and regulations of Pennsylvania and New York and to the prior approval and/or reporting requirements of other jurisdictions in which we a