PENN TREATY AMERICAN CORP
Form 10-K
May 03, 2005

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

FORM 10-K

[X] Annual Report pursuant to section 13 or 15(d) of the Securities Exchange Act of 1934 For the fiscal year ended **December 31, 2004**

or

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

Commission file number: 001-14681

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, par value $.10 per share
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 (section 229.405 of this chapter) 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]

Indicate by checkmark whether the registrant is an accelerated filer (as defined in Rule 12b-2 of the Act.)
Yes [ ] No [X]

Based upon the last sale price of the registrant s Common Stock on June 30, 2004, the aggregate market value of the 37,312,523 outstanding shares of voting stock held by non-affiliates of the registrant was $74,998,171.

As of April 27, 2005, 48,340,130 shares of the registrant s Common Stock were issued and outstanding.

Documents Incorporated by Reference:

Portions of the following documents are incorporated by reference in the Annual Report on Form 10-K:

The registrant s definitive Proxy Statement for its 2004 Annual Meeting of Stockholder to be filed not later than 120 days after the close of the fiscal year (incorporated into Part III).

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PART I

Item 1. Business

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 those described in Risk Factors beginning on page 6.

(a) The Company and the Long-term Care Insurance Industry

Penn Treaty American Corporation

We are a leading provider of long-term care insurance in the United States. Our principal products are individual, defined benefit accident and health insurance policies covering long-term care services, including confinement to nursing facilities and assisted living facilities, as well as home health care. Our policies are designed to provide meaningful benefits if and when the insured is no longer capable of functioning independently. We also own insurance agencies that sell senior-market insurance products issued by us as well as other insurers.

We introduced our first long-term nursing home insurance product in 1972 and our first home health care insurance product in 1983. Since then we have developed several new products designed to meet the changing needs of our customers that were the first of their kind in the long-term care industry. Our primary product offerings are:

- The Assisted Living Plus® policy, which provides coverage for all levels of facility care and includes an optional home health care rider;
- The Personal Freedom® policy, which provides comprehensive coverage for facility and home health care;
- The Independent Living® policy, which provides coverage for home and community-based care furnished by licensed care providers, as well as unlicensed caregivers;
- The Post Acute Recovery policy, which provides coverage for short-term recuperative care received in a long-term care facility, or the policyholder s home;
- The Secured Risk® product, which is a limited benefit policy designed for substandard risks; and
- Simple LTC Solution[SM], which offers a new and simplified approach to long-term care insurance, and includes innovative features, such as a policyholder co-payment for covered services.

Although nursing home and home health care policies accounted for approximately 95% of our total annualized premiums in-force as of December 31, 2004, we also market and sell Medicare supplement policies.

We maintain and administer one of the largest individual long-term care insurance portfolios in the industry. Our sales and marketing efforts through our independent agency distribution channels were very successful between 1995 and 2000 as total in-force premiums grew at a compound annual rate of approximately 29% from $102 million to $360 million. Our total long-term care in-force premiums were approximately $326 million at December 31, 2004.

In 2001, we ceased new policy sales nationwide as a result of insufficient statutory surplus levels until we formulated a Corrective Action Plan (the Plan) with the Pennsylvania Insurance Department (the Department). Both Penn Treaty Network America Insurance Company (PTNA) and American Network Insurance Company (ANIC), which represent approximately 91% and 8% of our direct premium revenue, respectively, are subject to the Plan. Upon the Department s approval of the Plan in February 2002, we recommenced new policy sales in 23 states, including Pennsylvania. We have now recommenced new policy sales in 18 additional states, including Florida and California (both subject to Corrective Orders). Florida, California and Pennsylvania accounted for approximately 16%, 15% and 12%, respectively, of our direct premium revenue for the year ended December 31, 2004. We are working with the remaining states to recommence new policy sales in all jurisdictions.

As part of the Plan, effective December 31, 2001, we entered into a reinsurance agreement with Centre Solutions (Bermuda) Limited to reinsure, on a quota share basis, substantially all of our respective long-term care insurance policies then in-force. The agreement is subject to certain coverage limitations and an aggregate limit of liability, which may be reduced if we are unable to obtain premium rate increases required by the agreement. The agreement meets the requirements to qualify as reinsurance for statutory accounting, but not for generally accepted accounting principles (GAAP). As the agreement is treated as reinsurance for statutory accounting purposes, it results in the cession (or removal) of substantially all of PTNA s and ANIC s policy reserve and claim reserve liabilities for statutory accounting purposes.

Corporate Background

Penn Treaty American Corporation (Penn Treaty) is registered and approved as a holding company under the Pennsylvania Insurance Code. Penn Treaty was incorporated in Pennsylvania on May 13, 1965 under the name Greater Keystone Investors, Inc. and changed its name to Penn Treaty American Corporation on March 25, 1987. Our primary business is the sale of long-term care insurance, which we conduct through the following subsidiaries:

- Penn Treaty Network America Insurance Company a Pennsylvania-based insurance company;
- American Network Insurance Company a Pennsylvania-based insurance company; and
- American Independent Network Insurance Company of New York a New York-based insurance company.

We also conduct insurance agency operations through the following subsidiaries:

- Senior Financial Consultants Company a Pennsylvania-based insurance agency brokerage;
- United Insurance Group Agency, Inc. a Michigan-based consortium of long-term care insurance agencies; and
- Network Insurance Senior Health Division-a Florida-based insurance agency brokerage.

The Long-Term Care Insurance Industry

Based on the 2004 Annual Survey by LIMRA International:

- Industry-wide long-term care insurance sales were down by 25% in 2004, on a premium basis, primarily due to premium rate increases on older polices and higher premium rates on new policies. Approximately $699 million in new annual policy premiums were issued in 2004 compared to $935 million in 2003.
- Total in-force premium has grown over the past 10 years. From 1999 to 2004, in-force premium grew at a compound average growth rate of 12%, compared to a compound average growth rate of 16% from 1998 to 2003.
- The total number of in-force policies at the end of 2004 exceeded four million, with in-force annualized premium reaching $6.8 billion.

Given the projected demographics of the U.S. population, the rising costs of home health care and long-term care, the associated challenges faced by Medicaid, and current and proposed state and federal legislation that support the purchase of private long-term care insurance coverage, we believe the potential for future growth remains significant.

According to a 2000 U.S. Census Bureau report, the population of senior citizens (people age 65 and over) in the United States is projected to grow from an estimated level of approximately 35 million in 2002 to approximately 70 million by 2030. Furthermore, health and medical technologies are improving life expectancy and, by extension, increasing the number of people requiring some form of long-term care. The projected growth of the target population indicates 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, along with the increasing strain these services are having on the state and federally financed Medicaid system (which is the largest payer of long-term care services) makes long-term care insurance an attractive means to pay for these services. According to a 2005 report by the Centers for Medicare and Medicaid Services, the combined cost of home health care and nursing home care was $20.0 billion in 1980. By 2001, this cost rose to $134.9 billion. These costs are projected to rise to $160.6 billion in 2004 and $170.9 billion in 2005.

Our Strategy

We seek to enhance shareholder value by strengthening our position as a leading provider of long-term care insurance. Our value proposition incorporates innovative product development, stratification of underwriting risk, efficient and effective underwriting and an individualized service culture for agents and policyholders. We intend to achieve our goal of profitable growth by executing the following strategies:

Recommencement of sales and marketing efforts in all states. In 2001, we ceased new policy sales nationwide as a result of diminished surplus levels. We have since recommenced new policy sales in 41 states, which represented approximately 90% of our direct premium revenue in 2004. We are working with the insurance departments of the remaining states to recommence new policy sales in all jurisdictions.

The sale of our current policies, which we believe are priced with appropriate profit margins, is an important component of our earnings per share growth in the future. Although the in-force business we sold before 2002 remains marginally profitable, sales of new policies are expected to be a driving force in generating profits in the future. In 2004, sales of our current generation of long-term care insurance products totaled approximately $17.3 million on an annualized premium basis, 35% above the sales level of 2003.

Reengagement of our existing sales force and the expansion of distribution opportunities. In connection with our efforts to recommence sales, we have also been actively involved in reengaging our network of agents. We recognize that our ability to generate new policy sales is highly dependent on agents who understand the needs of our target market. We intend to continue to recruit agents as we recommence new policy sales throughout the United States.

Besides providing innovative products, competitive commissions and personalized service, our strategy to reengage our sales force is highly dependent upon our claims paying ability, ratings from independent rating agencies, our financial strength and our reputation with agents and policyholders.

We believe that the actions we have taken, which included increasing statutory capital through the issuance of new convertible debt, will enhance the likelihood that insurance rating agencies will increase our ratings. In addition, we plan to continue our focus on agent communication and education by providing our sales force with periodic updates regarding the progress achieved in our execution of the Plan.

Enhancement of our leadership team and financial management capability. Since 2001, we began to strengthen our leadership team through the addition of individuals with the experience and skills necessary to create value for all of the Company s stakeholders, which include our investors, policyholders, agents and employees.

Our directors and senior executives have a wide breadth of financial services industry experience. In May 2004, Patrick Falconio, a former insurance company executive, was appointed to the Board of Directors. In 2004, we realigned our management team by creating a new position, Executive Vice President of Strategic Operations, which was assumed by the former Chief Financial Officer. The Chief Accounting Officer advanced to Chief Financial Officer. In 2005, our leadership team was further enhanced through the addition of a Senior Vice President of Claims Management and Policyholder Services who has over 20 years of healthcare and long-term care insurance risk management experience. The former Senior Vice President in charge of claims management and policyholder services maintains leadership over our underwriting and compliance functions and assumed responsibility for all product development efforts.

Increase our operational efficiency through technological improvements. In 2002, we embarked on a system replacement project (SRP), initiated to redesign our long-term care administration systems over the subsequent three years. In 2005, after evaluating the projected timing and expense of completing our SRP internally, we entered an agreement with an outside vendor to customize an existing operating system for our own unique needs, while maximizing the use of our efforts and capitalized costs to date. The revised SRP, which is expected to be completed over the next 18 months, includes the assessment of each major task performed in our daily operations and the identification of value and non-value added functions. As part of the SRP, we are redesigning each major process within our business model in order to gain operational efficiency through the redesign and deployment of our resources. The SRP design is specific to the processing and administration of long-term care insurance.

Development and approval of new products. We have sold long-term care insurance for over 30 years. As an innovator in nursing home and home health care insurance products, we have introduced many new policies over the years. We continually discuss long-term care insurance needs with our agency sales force and policyholders. As a result, we are able to design new products and offer what we believe to be the most comprehensive benefit features in the industry. The development of new products enables us to generate new business and provide advancements in the benefits we offer. We have developed our next generation of long-term care insurance products and have filed these products with the insurance department of each state in which we are currently approved to sell new policies. These products have been updated to include greater flexibility of benefit design and to incorporate additional coverage options, including expanded spousal benefits. We have also recently introduced our Simple LTC Solution[SM] product, which offers a simple approach to long-term care insurance and incorporates a policyholder co-payment for covered care.

Risk Factors

The risks and uncertainties described below are not the only ones we face. Additional risks and uncertainties that we do not currently know about or currently believe are immaterial, or which are similar to those faced by other companies in our industry or business in general, are not specifically identified below, but may nevertheless adversely affect our business. If any of the risks actually occur, our business, financial condition or future results of operations could be materially and adversely affected.

Our business could be materially adversely affected if we were unable to continue selling policies or are unsuccessful in recommencing new policy sales in a few key states.

Historically, our business has been concentrated in a few key states. During 2004, approximately 43% of our direct premium revenue came from sales of policies in California, Florida and Pennsylvania. Although, we have recommenced new policy sales in 41 states, including California, Florida and Pennsylvania, we have not yet recommenced new policy sales in nine other states. We are working with the remaining states to recommence sales in all jurisdictions.

We have agreed to conditions for the recommencement of business in California, Florida, Illinois and Pennsylvania. If we were found not to be in compliance with these conditions, we could be forced to stop new policy sales. Each state insurance department may impose its own conditions on our recommencing or continuing new policy sales in its state. If we are unable to continue selling new policies in our key states, our financial condition and results of operations could be materially adversely affected.

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

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

We have significant convertible debt and may be unable to service and repay our debt obligations, which could cause a payment default.

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 convertible 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 the Plan with the Department, which restrict their ability to pay dividends and make other payments to us, and could require the parent to make further capital contributions to their surplus in the future.

Our ability to service our debt obligations is dependent upon our parent company expenses and liquidity and agency dividend capabilities. If our debt is not converted into shares of our common stock, if we are unable to generate sufficient funds through operations or raise additional capital to meet our debt service obligations in or after October 2006 or if our assumptions about our ability to service our debt prior to 2006 are not correct, we may default on our debt obligations, which could result in our having to cease doing business.

We could suffer a loss if our premium rates are not adequate and we are unable to obtain necessary state approvals for premium rate increases.

We set our premiums based on assumptions about numerous variables, including our estimate of the probability of a policyholder making a claim, the severity and duration of such claim, the mortality rate of our policyholders, the persistency or renewal of our policies in-force and the amount of interest we expect to earn from the investment of premiums. In setting premium rates, we consider historical claims information, industry statistics and other factors.

Based on our recent studies, we believe that the policies we currently offer are priced to provide a satisfactory profit margin. However, those studies also suggest that certain of our older policies are only marginally profitable and some are unprofitable. As a result, we commenced efforts to obtain premium rate increases on such polices, which may include some policies that previously received a premium rate increase. If our actual experience proves to be less favorable than we assumed, our financial condition and results of operations could be materially adversely affected.

We generally cannot raise our premium rates in any state unless we first obtain the approval of the insurance regulator in that state. 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 premium rate increase in one or more states, our financial condition and results of operations could be materially adversely affected.

Premium rate increases could lead to anti-selection, which is the lapsation of policies held by healthier policyholders. Anti-selection could cause our actual claims experience to exceed our expectations based on the higher risk of the remaining policyholders. As a result, our financial condition and results of operations could be materially adversely affected.

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

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

Our unamortized deferred policy acquisition cost asset may not be fully recoverable, which would result in an impairment charge and could materially adversely affect our financial condition and results of operations.

In connection with the sale of our insurance policies, we defer and amortize the policy acquisition costs over the related premium paying periods throughout the life of the policy. These costs include all expenses that are directly related to, and vary with, the acquisition of the policy, including commissions, underwriting and other policy issue expenses. The amortization of deferred policy acquisition costs (DAC) is determined using the same projected actuarial assumptions used in computing policy reserves. DAC can be affected by unanticipated terminations of policies because, upon such terminations, we are required to expense fully the DAC associated with the terminated policies. In addition, we review and update the assumptions underlying DAC and our policy reserves to reflect current experience on a quarterly basis. If, based on that review we determine that our DAC is not fully recoverable, we would impair the value of our DAC and would fully expense the impaired amount. As a result, our financial condition and results of operations could be materially adversely affected.

Declines in the value of, or the yield on, our notional experience account or our investment portfolio could adversely affect our financial condition and results of operations.

Our reinsurance agreement with Centre Solutions (Bermuda) Limited reinsures, on a quota share basis, substantially all of our long-term care insurance policies in-force at December 31, 2001 under statutory accounting rules. The reinsurer maintains a notional experience account for our benefit in the event of commutation. The notional experience account reflects the initial premium paid, subsequent premiums collected net of claims, expenses and accumulated investment earnings. The notional experience account balance receives an investment credit based on the total return of a series of benchmark indices and hedges, which are designed to match closely the duration of our reserve liabilities. As a result, we have experienced, and may continue to experience, significant volatility in our financial condition and results of operations.

Income from our investment portfolio is an element of our overall net income. We are susceptible to changes in market interest rates when cash flows from maturing investments are reinvested at prevailing market rates. If our investments do not perform well, our financial condition and results of operations could be materially adversely affected.

In addition, in establishing the level of our reserves for future policy claims and benefits, 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 materially adversely affect our financial condition and results of operations.

Our reinsurance agreement with Centre Solutions (Bermuda) Limited is subject to an aggregate limit of liability, which, if exceeded, could adversely affect our financial condition and results of operations.

Our reinsurance agreement with Centre Solutions (Bermuda) Limited is subject to certain coverage limitations and an aggregate limit of liability. The aggregate limit of liability may be reduced if we are unable to obtain premium rate increases deemed necessary under the provisions of the agreement and if certain other events occur. If the aggregate limit of liability is expected to be exceeded, we would be unable to receive full statutory credit for the cession of our reserves, resulting in the reduction of our statutory surplus and the possible breach of this provision of the Plan.

In the event that (1) the reinsurer s limit of liability is reduced or exceeded, (2) the reinsurance agreement is cancelled, (3) our reinsurer is not able to satisfy its obligations to us or (4) we breach the Plan, our financial condition, results of operations and statutory surplus could be materially adversely affected.

We may have insufficient capital and surplus to commute our reinsurance agreement with Centre Solutions (Bermuda) Limited, which could adversely affect our financial condition and results of operations and cause substantial dilution to shareholders.

We are entitled to commute (i.e., recapture the statutory reserve liabilities on the underlying policies) our reinsurance agreement with Centre Solutions (Bermuda) Limited on December 31, 2007 or any December 31 thereafter. To be able to do so, we would be required to have amounts of statutory capital and surplus which would support recapturing the statutory liability for such policies. We do not currently have enough statutory capital and surplus to do so. While we believe, based upon our most recent projections and modeling, that it is probable that our business will be sufficiently profitable in the future such that we will have a sufficient amount of statutory capital and surplus to do so by December 31, 2007 and that viable alternatives, such as new reinsurance opportunities or additional capital issuances, are available to enable us to commute the agreement, there is no assurance that we will be able to commute the reinsurance agreements.

If we do not commute the agreement on December 31, 2007, the amounts assessed against our notional experience account to Centre Solutions (Bermuda) Limited under the reinsurance agreement will be substantially increased. In addition, in such circumstances, Centre Solutions (Bermuda) Limited would become entitled to exercise a fourth tranche of warrants. The warrants are exercisable for convertible preferred stock which, if converted, and when combined with the potential conversion of preferred stock issuable upon exercise of the first three tranches of warrants (which would expire on December 31, 2007 if unexercised), would result in the issuance to Centre Solutions (Bermuda) Limited of approximately 35% of our common stock outstanding after such issuance on a fully diluted basis. The issuance of such shares would substantially dilute the interest of our existing shareholders.

Policies issued after August 1, 2004 are not reinsured and our inability to find a reinsurer could limit our ability to issue new business without reducing our statutory surplus and materially adversely affect our financial condition and results of operations.

On March 29, 2004, Centre Solutions (Bermuda) Limited notified us that, for reasons unrelated to us, it would discontinue its quota share reinsurance of new long-term care insurance policies issued after July 31, 2004. Policies issued prior to August 1, 2004 will be unaffected by the termination of the agreement. We have been attempting to obtain alternative reinsurance since March 29, 2004 but have not been successful. In the event that we are unable to obtain reinsurance from another carrier for policies issued on or after August 1, 2004, or find other sources of statutory surplus, our ability to issue new business without reducing statutory surplus could be limited and our financial condition and results of operations could be materially adversely affected.

Our reinsurers may not satisfy their obligations to us, which could materially adversely affect our financial condition and results of operations.

We obtain reinsurance from unaffiliated reinsurers, in addition to Centre Solutions (Bermuda) Limited, on certain of our policies. Although each reinsurer is liable to us to the extent the risk is transferred to such reinsurer, reinsurance does not relieve us of liability to our policyholders. Accordingly, we bear credit risk with respect to all of 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. The failure of our reinsurers to make such payments could have a material adverse effect on our financial condition and results of operations.

PTNA is a party to a reinsurance agreement to cede the risk of certain home health care claims that extend beyond 36 months. Reinsurance recoverables related to this agreement were approximately $11.2 million at December 31, 2004. The reinsurer has notified PTNA that it believes that the Company is in breach of this agreement as a result of entering the 2001 Centre Agreement without the prior written approval of the reinsurer. The ultimate resolution of this dispute cannot be determined at this time.

We may not be able to compete successfully with insurers that have greater financial resources or better 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 than we are and many have greater resources and better financial strength ratings than we do. Most insurers also have not experienced the regulatory problems we have faced. 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 insurance carriers introducing products similar to those offered by us.

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, affect our ability to expand and to attract new business. 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). 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) with positive outlook.

Certain distributors will not sell our products unless we have a more favorable financial strength rating. Similarly, certain prospective customers may decline to purchase new policies because of a perceived risk of non-payment of policy benefits due to our financial condition. Our inability to achieve improved ratings could have a material adverse effect on our financial condition and results of operations.

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

Our insurance subsidiaries are subject to comprehensive regulation by state insurance regulatory authorities. 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, regulating 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. The primary purpose of such regulation is to protect policyholders, not shareholders.

State legislatures, 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 financial condition and results of operations and could make it difficult or financially impracticable to continue doing business. Some states limit premium rate increases on long-term care insurance products and other states have considered doing so. Because insurance premiums are our primary source of income, our financial condition and results of operations could be negatively affected by any of these changes.

Certain legislative proposals could, if enacted or further refined, adversely affect our financial condition and results of operations. 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. 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 field marketing organizations 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. When we ceased new policy sales in 2001, many of our agents began selling more long-term care insurance products issued by our competitors. We may not be able to attract (or in the case of agents who have begun writing long-term care products for our competitors, to re-engage) and retain independent agents to sell our products, especially if we are unable to obtain permission to recommence new policy sales in the nine states where we are currently not permitted to offer new policies. Because our future profitability depends primarily on new policy sales, our business and ability to compete would suffer if we are unable to recruit and retain insurance agents or if we lost the services provided by our field marketing organizations.

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

Current and future litigation may result in financial losses, harm our reputation and require the dedication of significant management resources. We are regularly involved in litigation. The litigation naming us as a defendant ordinarily involves our activities as an insurer. In recent years, many insurance companies, including us, have been named as defendants in class actions relating to market conduct or sales practices, and other long-term care insurance companies have been sued when they sought to implement premium rate increases. See Item 3 Legal Proceedings for a description of current legal proceedings.

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 our shareholders, or discourage a third party from attempting to acquire control of us. In particular, the classification and three-year terms of our directors could have the effect of delaying a change in control. Insurance laws and regulations of Pennsylvania and New York, our insurance subsidiaries states of domicile, 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.

The conversion of our debt, the exercise of our outstanding warrants and stock options and any future issuances of new shares of our common stock will result in significant dilution to our existing shareholders.

The conversion of our subordinated convertible debt will represent significant dilution to our existing shareholders. Also, if holders of our debt elect to convert their debt into shares of our common stock prior to October 15, 2005, we may issue additional shares of common stock as payment of a discounted amount of interest that would otherwise be payable through that date. In addition, we have granted warrants to Centre Solutions (Bermuda) Limited, which are exercisable until December 31, 2007 for preferred stock convertible into 15% of our then outstanding common stock after conversion on a fully diluted basis and an additional 20% of our then outstanding common stock after conversion on a fully diluted basis in the event that we do not commute our reinsurance agreement at or prior to December 31, 2007. We anticipate that to finance the growth of our business adequately and to support our liquidity needs, we may offer and sell additional shares of common stock or convertible debt in private or public offerings in the future. The occurrence of any or all of the foregoing will result in significant additional dilution to our existing shareholders.

We could be required to reduce certain tax attributes (such as credits, losses, etc.) and thereby owe greater federal income taxes.

The Internal Revenue Service has established rules that potentially limit or defer a company s use of prior period net operating loss carryforwards for tax purposes in the event that ownership of a majority of the company s common stock ownership changes during any three-year period. Due to the issuance of additional shares of our common stock since May 2001, we have become subject to these limitations or deferrals and have established a valuation allowance against the use of our net operating loss carryforwards. However, if our interpretation of the rules is incorrect, our valuation allowance is insufficient or we generate future losses that further limit our ability to use these net operating losses, we could be required to further reduce certain of our tax attributes and thereby owe greater taxes. In addition, we believe that the potential mandatory conversion of our convertible debt into shares of our common stock after October 15, 2005 will again subject us to these limitations or deferrals in the event further tax loss carryforwards are incurred. The payment of greater taxes would also adversely affect our statutory surplus. It is not possible for us to quantify the impact of such a further reduction in tax attributes and we are not certain that any such reduction would be required. However, such a reduction could have a material impact upon our financial condition and results of operations.

(b) Insurance Products

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

- the characteristics and needs of the senior insurance market;
- governmental regulations and governmental benefits available for senior citizens; and
- the health care and long-term care delivery systems.

As of December 31, 2004, approximately 95% of our total annualized premiums in-force were derived from long-term care policies, which include facility and home health care policies. Our other lines of insurance include Medicare supplement, life and disability products. We solicit input from both our independent agents and our policyholders with respect to the changing needs of the senior market. In addition, our representatives regularly attend regulatory meetings and seminars to monitor significant trends in the long-term care industry.

Our focus on long-term care insurance 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 a series of differentiated products.

The following table sets forth, at the dates indicated, information related to our policies in force:

	2004			2003			2002		
Long-term facility, home and comprehensive coverage:									
Annualized premiums	$ 326,030	95.3	%	$ 334,529	95.5	%	$ 344,771	95.7	%
Number of policies	172,324			185,608			204,429		
Average premium per policy	$ 1,892			$ 1,802			$ 1,687		
Disability insurance:									
Annualized premiums	$ 1,426	0.4	%	$ 1,590	0.5	%	$ 2,529	0.7	%
Number of policies	3,357			4,066			6,187		
Average premium per policy	$ 425			$ 391			$ 409		
Medicare supplement:									
Annualized premiums	$ 11,890	3.5	%	$ 10,887	3.1	%	$ 9,726	2.7	%
Number of policies	7,887			8,806			8,566		
Average premium per policy	$ 1,508			$ 1,236			$ 1,135		
Life insurance:									
Annualized premiums	$ 2,480	0.7	%	$ 2,715	0.8	%	$ 2,957	0.8	%
Number of policies	4,456			4,882			5,282		
Average premium per policy	$ 557			$ 556			$ 560		
Other insurance:									
Annualized premiums	$ 257	0.1	%	$ 321	0.1	%	$ 424	0.1	%
Number of policies	1,847			2,114			2,445		
Average premium per policy	$ 139			$ 152			$ 173		
Total annualized premiums in force	$ 342,083	100.0	%	$ 350,042	100.0	%	$ 360,407	100.0	%
Total Policies	189,871			205,476			226,909		

We received an insurance license in 1972, which permitted us to write insurance in 12 states. In 1974, we offered our first extended care long-term care policy, which was the first long-term care insurance product to cover all levels of facility care, including skilled, intermediate and custodial care, and which had an extended five-year benefit period.

In 1983, 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 1987, we began offering a stand-alone home care policy, which was the first in the industry to include a limited benefit for homemaker care provided by an unskilled, unlicensed individual such as a friend or neighbor.

In 1986, we began the use of table-based underwriting, which enables higher risk policyholders to receive coverage at a risk-adjusted premium rate. The table-based underwriting method considers medical conditions and the likelihood of an inability to perform daily activities developing to determine appropriate premium levels. Multiple rate classes enabled us to penetrate an untapped market in long-term care insurance sales.

Our long-term nursing facility policies provide a benefit payable during periods of nursing facility confinement prescribed by a physician or necessitated by a policyholder s cognitive impairment or inability to perform two or more activities of daily living (such as bathing or dressing). These policies also include built-in benefits for alternative plans of care, waivers of premiums after 90 days of benefit payments on a claim, and restoration of the policy s maximum benefit period. All levels of nursing care, including skilled, intermediate and custodial (assisted living), 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. Intermediate nursing care is designed to cover situations that would otherwise fall between skilled and custodial care and includes situations in which an individual may require skilled assistance on a sporadic basis. Custodial 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.

Our current long-term nursing home care policies provide benefits that are payable for defined benefit periods ranging from one to ten years, or the lifetime of the policyholder. Certain of these policies provide for a maximum daily benefit on an expense-incurred basis ranging from $60 to $300 per day. We also offer policies that provide comprehensive coverage for nursing home and home health care, and offer lifetime maximums that consist of pools of coverage , with the pools derived by multiplying the daily benefit selected by the number of days in the benefit period chosen.

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 unlicensed or unskilled homemakers. Benefits for our currently marketed home health care policies are payable for defined benefit periods ranging from one to five years, or the lifetime of the policyholder, and provide from $60 to $300 per day. Most of our policies generally also include built-in benefits for waiver of premiums after 90 days of benefit payments, and restoration of the policy s maximum benefit period.

We currently offer the following products:

Personal Freedom® policy. Our Personal Freedom® policy (offered since 1996) provides comprehensive coverage through a pool of money which is available to pay for long-term care services received in a nursing facility, an assisted living facility or the policyholder s home.

Assisted Living® policy. The Assisted Living® policy (offered since 1999) provides facility coverage in either a traditional nursing home setting or in an assisted living facility. This policy is a lower-priced alternative to the Personal Freedom® policy. When coupled with an optional home health care rider, the Assisted Living® policy offers benefits similar to those of the Personal Freedom® policy, but provides the policyholder with the flexibility to determine at the time of policy issuance how much coverage is available for each type of care, thereby fixing each potential risk and reducing the policy cost.

Independent Living® policy. The Independent Living® policy (offered since 1994) provides coverage for all levels of care received at home. Besides covering skilled care and care by home health care aides, this policy pays for care provided by unlicensed, unskilled homemakers. This care includes assistance with instrumental activities of daily living, such as cooking, shopping and housekeeping when determined to be medically necessary. Family members also may be reimbursed for any training costs incurred to provide in-home care.

Secured Risk® policy. Our Secured Risk® policy (offered since 1998) provides limited 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 applicants based on their level of activity and independence. This policy provides coverage for all types of care, but with coverage limitations and longer elimination period (initial time period not covered by insurance) requirements than our other policies.

Post Acute Recovery policy. The PAR policy (offered since 1999) offers short-term benefits for long-term care services. The plan is generally purchased to provide supplemental coverage due to its limited benefits and reduced price.

Simple LTC Solution[SM] policy. The Simple LTC Solution[SM] policy, which was filed in 2004 and which we are just beginning to offer, is intended to provide a simplified, more affordable approach to long-term care insurance. This policy covers confinement in a nursing or assisted living facility and home health care and includes cost-controlling features such as an automatic deductible, an ongoing policyholder co-payment, and a fixed, limited lifetime maximum that does not restore.

Riders. We offer numerous riders to our base policies, including inflation protection, which provides escalating benefit amounts, and a non-forfeiture benefit, which guarantees certain paid-up benefits in the event the policy lapses in the future.

Tax qualified and non-qualified policies. With the enactment of the Health Insurance Portability and Accountability Act of 1996, we began offering a tax qualified policy, which allows for certain income tax deductions for premium payments and provides benefit payments that are not subject to tax. We continue to offer both tax-qualified and non-tax-qualified policies, with the non-tax-qualified policies having more access to benefits, but also not having the same preferential tax treatment as a tax-qualified policy.

(c) Marketing

Markets. The following chart shows premium revenues by state (dollar amounts in thousands):

		($000)			
		Year Ended December 31,			Current
State	Year Entered	2004	2003	2002	Year % of Total
Arizona	1988	$ 13,671	$ 13,947	$ 14,267	4.3%
California	1992	46,585	45,618	48,899	14.6%
Florida	1987	50,435	55,907	58,990	15.8%
Illinois	1990	17,535	17,104	17,472	5.5%
New Jersey	1996	6,756	6,887	7,695	2.1%
North Carolina (2)	1990	9,430	9,366	9,919	2.9%
Ohio (2)	1989	9,248	9,970	10,664	2.9%
Pennsylvania	1972	39,392	43,850	40,247	12.3%
Texas	1990	15,742	15,803	16,587	4.9%
Virginia	1989	22,477	23,008	21,442	7.0%
Washington	1993	10,270	10,060	10,407	3.2%
All Other States (1)		78,344	70,426	77,054	24.5%
All States		$ 319,885	$ 321,946	$ 333,643	100.0%

(1) Includes all states with premiums of less than two percent of total premiums in 2004.

(2) We have not recommenced new policy sales in these states or in seven other states which are included in All Other States.

Historically, our business has been concentrated in a few key states. During 2004, approximately 43% of our direct premium revenue came from sales of policies in California, Florida and Pennsylvania. In 2001, we ceased new policy sales nationwide as a result of our statutory surplus levels until we formulated the Plan with the Department. Upon the Department s approval of the Plan in February 2002, we recommenced new policy sales in 23 states, including Pennsylvania. We have now recommenced new policy sales in 18 additional states, including California and Florida. We are working with the remaining states to recommence new policy sales in all jurisdictions.

The following table summarizes our sales of new policies in the periods indicated (in thousands):

	2004	2003	2002
Number of new policies sold	8	7	3
Annualized premiums	$ 17,969	$ 13,722	$ 5,274

Our sales and marketing mission is to provide our distribution partners with a full line of long-term care insurance products that are diverse in benefit structure, competitively priced, have a wide underwriting window and are also backed by personalized service. We provide training and marketing solutions to our agents so they in turn can grow their sales volume. We closely monitor the long-term care health care delivery system and develop products designed to provide us with a competitive edge in the long-term care insurance market segment. We measure our success by the growth of new business sales and the retention of our current policyholders.

Distribution Partners. Our distribution strategy for 2005 includes a four-pronged marketing approach including:

1) Field Marketing Organizations
2) Penn Treaty Career Agent Division
3) PTAdvantage[SM]
4) Strategic Alliances

Field Marketing Organizations. We will continue marketing our products through Field Marketing Organizations (FMOs) which are large multi-agent networks utilized for the purpose of recruiting independent agents and developing networks of agents in various states. FMOs receive an override commission on business written in return for recruiting, training and motivating independent agents to place business.

The FMOs actively recruit independent agents who must be authorized by contract to sell our products in each state in which the agent and our insurance subsidiaries are licensed. Some of our independent agents are large general agencies with many sales persons (sub-agents or captive agents), while others are 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 competitors.

We believe the commissions we pay to independent agents are competitive with the commissions paid by other insurance carriers selling similar products. The independent agent s right to renewal commissions is vested and renewal commissions are paid as long as the policy remains in-force, provided the agent continues to abide by the terms of the contract.

Penn Treaty Career Agent Division. Our newly created Career Agent Division, administered through our subsidiary, UIG, operates in 12 states, with approximately 100 agents. These are captive agents which are dedicated to selling our products.

PTAdvantage[SM]. During the fourth quarter of 2004, we launched PTAdvantage[SM], an innovative insurance marketing protocol developed by Insurance IQ. PTAdvantage[SM] is designed to facilitate the recruitment of new FMOs and life insurance agents to sell the Company s long-term care insurance products.

Strategic Alliances. In 2004, we began exploring partnerships with competing long-term care insurance carriers who have captive sales agents who would benefit from offering our long-term care insurance products. We offer these carriers a revenue stream, increased agent retention and a reimbursement of a portion of their underwriting expense upon the issuance of new business. During the remainder of 2005, we will strive to cultivate new strategic alliances and increase the volume of sales from current strategic alliances.

Product Portfolio. In the second quarter of 2004, we introduced our newest generation of flagship long-term care insurance products, building on our current brand names, Personal Freedom®, Independent Living® and Assisted Living Plus®. These products contain a fresh new design with a basis in our long history of long-term care insurance product innovation. The plans were designed based upon input from our top distributors, who have vast industry knowledge, and offer unique benefit structures at competitive rates.

In 2005, we are introducing a new product named Simple LTC Solution[SM]. This innovative product offers a less expensive solution to long-term care insurance needs with simplified policy benefits and introduces a policyholder co-payment feature.

Additionally, in the first quarter of 2005, we were approved to join the Connecticut Partnership for Long-Term Care. As a member of this partnership, we will sell our flagship long-term care insurance plan Personal Freedom® 3. The state of Connecticut has taken an active role in the promotion of long-term care insurance coverage and its benefits to consumers and the majority of statewide sales are made by partnership members. With Personal Freedom® 3, we offer the greatest diversity of underwriting classes in the partnership.

Product Diversification. In the third quarter of 2004, we diversified our product line by introducing a traditional Medicare Supplement policy in nine states. We believe that the target market for Medicare Supplement plans is similar to that of long-term care insurance. We also believe that a certain level of product diversity is viewed favorably by independent rating agencies.

(d) Administration

Underwriting

We believe that the underwriting process through which we choose to accept or reject an applicant for insurance is critical to our success. We have offered long-term care insurance products for 30 years and we believe we have benefited significantly from our longstanding focus on this specialized line. Through our experience, we have been able to establish a system of underwriting designed to permit us to process our new business and assess the risks presented with new applications more effectively and efficiently. This experience has also enabled us to devise a risk stratification system whereby we can accept a broad array of risks with correspondingly appropriate premium levels.

Applicants for long-term care insurance are required to complete applications and answer detailed medical questions about their health history, medications, and other personal information. Additionally, each applicant must complete a telephonic or face-to-face interview conducted by an employee of our underwriting department or a nurse through an outside agency. These interviews are used to verify the information provided on the application, as well as obtain additional insight into an applicant s physical abilities, activity level, living situation and cognitive functioning.

As part of these interviews, all applicants are screened for cognitive impairment, a major contributor to the need for long-term care services. For those under age 65, the Delayed Word Recall screen is utilized. For those 65 and older, the Minnesota Cognitive Acuity Screen (MCAS) is performed by an outside agency. Unless the underwriting department determines that an in-home assessment is required, the MCAS is generally conducted telephonically for applicants between 65 and 74 years of age. For those ages 75 and over, an in-home assessment incorporating the MCAS is required. Depending on the applicant s health history, copies of an applicant s medical records are also frequently required. Our underwriting evaluation process not only assesses the risk the applicant currently represents, but also takes into account how existing health conditions and risk factors are likely to progress and affect an applicant s level of independence as he or she ages.

We use table-based underwriting, or multiple rate classifications, as a means to approve a greater number of applicants by obtaining the premiums for appropriate additional risk levels. Applicants are placed in different risk classes for acceptance and premium calculation based on medical conditions and level of activity. We have an underwriting points-based scoring system, which provides consistent underwriting and rate classification for applicants with similar medical histories and conditions. We currently offer Preferred, Premier, Select and Standard risk classifications. We are able to offer the equivalent of a fifth underwriting class through our Secured Risk® product, which allows us to accept applicants who would not otherwise qualify for traditional long-term care insurance products.

Claims

Our long-term care insurance claims are evaluated and processed by our internal staff, which includes our care management unit. All Medicare Supplement claims are processed by a third party administrator.

Approximately half of our long-term care claims are for home health care. These claims typically require the greatest amount of overview and we have been utilizing care management techniques for over 10 years. Most of our policies offer the insured an incentive to provide early notice of claim. This early notice allows us to become involved with the claim shortly after the care begins, and sometimes even before it begins. Involvement with the claim at this stage is integral to our being able to deploy our care management approach in the most effective manner. Through care management, we are able to assess the insured s deficiencies and develop a plan of care, which sets out the type, intensity and duration of services required, that is appropriate to the insured s needs. Our care managers follow the claimant s progress with periodic contact and adjust the plan of care as needs change. These efforts are aimed at not only ensuring the plan of care is appropriate, but also at assisting the policyholder to return to the highest possible level of functioning as quickly as possible.

Our care management is administered through our care management unit, which consists of registered nurses that we employ, as well as through independent case management vendors, which offer a network of field assessors. Our in-house nurses conduct assessments and manage the cases telephonically, whereas external vendors are typically utilized for face-to-face assessments. Some form of care management is employed on over 95% of our home care claims. Additionally, one-third of our home care claimants also utilize our Care Solutions service, which is also administered by our care management unit. Through this service, we develop the plan of care and assist in setting up the care itself by identifying providers in and around the policyholder s community that we have relationships with, and by coordinating the delivery of that care. By utilizing our Care Solutions service, many policyholders qualify to obtain expanded home health care benefits under the provisions of our policies.

Our facility claims represent the other portion of our long-term care claims. These are comprised of claims for confinements to both traditional nursing facilities and assisted living facilities. The widespread availability of and consumer preference for assisted living facilities represents the most significant change in the long-term care delivery system in the past 10 years. These facilities have also impacted the types of facility claims we receive, where the level of disability and need for confinement may be less clear-cut than with a claim for the traditional nursing home. In 2004, we continued to increase utilization of face-to-face assessments as a tool for determining benefit eligibility and identifying the care needs of policyholders with facility-based claims.

We are presently refining our claims management and care management techniques and believe there is significant potential for future claims savings. The refinements include automating certain claims adjudication tasks, expanding the number and geographic distribution of skilled long-term care providers and network discounts that our policyholders can utilize, and focusing more resources on identifying and mitigating fraud. In 2004, we fully implemented a new pre-approval process for unskilled private or family caregivers. This process ensures the caregivers are qualified to meet the care needs of the policyholder.

Systems Operations

We maintain our own computer system for most aspects of our operations, including policy issuance, billing, claims processing, commissions, premiums and general ledger. We consider it critical to continue to provide the quality of service for which we are known by our policyholders and agents. We believe that our overall systems are an integral component in delivering that service. In 2002, we embarked on a system replacement project (SRP), initiated to redesign our long-term care administration systems over the subsequent three years. After evaluating the projected timing and expense of completing our SRP internally, we entered an agreement with an outside vendor in the first quarter of 2005 to customize an existing operating system for our own unique needs, while maximizing the use of our efforts and capitalized costs to date. The revised SRP, which is expected to be completed over the next 18 months, includes the assessment of each major task performed in our daily operations and the identification of value and non-value added functions. As part of the SRP, we are redesigning each major process within our business model in order to gain operational efficiency through the redesign and deployment of our resources. The SRP design is specific to the processing and administration of long-term care insurance.

The SRP is expected to provide us with a system that will support our business plan, allow us to grow the business without a significant increase in staffing, transform our existing processes from clerical-based to knowledge-based, and allow us to continue to provide and improve our services to both agents and policyholders. We believe the SRP will result in annual savings once the entire system is in place. These savings are expected to be achieved through productivity improvements, labor avoidance costs, and a reduction in the transaction error rates caused by manual processing. We believe the project will be implemented in the first half of 2006.

We have an outsourcing agreement with a computer services vendor providing for the daily operations of our systems, future program development and assurance of continued operations in the event of a disaster or business interruption. In addition, all processing of our newly introduced Medicare Supplement business is performed by a third-party administrator. We believe that these vendors can provide better expertise in the evolving arena of information technology and Medicare Supplement processing than we can.

(e) Premiums

Our long-term care policies provide for guaranteed renewability, at the option of the policyholder, at then current premium rates. The policyholder 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, which vary greatly among jurisdictions. Premium rates for our insurance policies are established by our actuarial staff with the assistance of our actuarial consultants and after consultation with executive management. All premium rates, including changes to previously approved premium rates, must be approved by the insurance regulatory authorities in each state. However, regulators may not approve the premium rate 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 by state regulations, the premiums on our existing and future Medicare Supplement policies 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.

In the past, we have filed with and received approval from certain state insurance departments to increase policy premium rates. These premium rate increases have resulted from a) claims experience that has differed from our expectations at time of original policy issuance, and b) development of alternative forms of facility care (assisted living centers) which were not contemplated at time of original policy issuance, but for which we have frequently made payment under the terms of our existing facility-based policy forms.

We have and are continuing to file and implement premium rate increases on the majority of our policies sold prior to 2002.

(f) Future Policy Benefits, Claims Reserves and Deferred Acquisition Costs

Our insurance policies are accounted for as long duration contracts. As a result, there are two components of policyholder liabilities. The first is a policy reserve liability for future policyholder benefits, represented by our estimate of the present value of future benefits less future premium collection. These reserves are calculated based on assumptions that include estimates for mortality, morbidity, interest rates, premium rate increases and persistency. The assumptions are based on industry experience, our historical results and recent trends.

The second is a reserve for claims which have already been incurred, whether or not they have yet been reported. The amount of reserves relating to claims incurred is determined by periodically evaluating statistical information with respect to the number and nature of historical claims. We regularly review our claims reserves, and any adjustments to previously established claims reserves are recognized in operating income in the period that the need for such adjustments becomes apparent.

In connection with the sale of our insurance policies, we defer and amortize the policy acquisition costs over the related premium paying periods throughout the life of the policy. These costs include all expenses that are directly related to, and vary with, the acquisition of the policy, including commissions, underwriting and other policy issue expenses. The amortization of deferred policy acquisition costs (DAC) is determined using the same projected actuarial assumptions used in computing policy reserves. DAC can be affected by unanticipated terminations of policies because, upon such terminations, we are required to expense fully the DAC associated with the terminated policies. In addition, we review and update the assumptions underlying DAC and our policy reserves to reflect current experience on a quarterly basis. If, based on that review, we determine that our DAC is not fully recoverable, we would impair the value of our DAC and would fully expense the impaired amount.

We use an in-house actuarial staff and a firm of actuarial consultants to assist us in establishing reserves. Additionally, actuaries assist us in the documentation of our reserve methodology and in determining the adequacy of our reserves and their underlying assumptions, a process that has resulted in adjustments to our reserve levels from time to time. 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.

(g) Reinsurance

Reinsurance Agreements with Centre Solutions (Bermuda) Limited

Effective December 31, 2001, we entered into a reinsurance agreement with Centre Solutions (Bermuda) Limited to reinsure, on a quota share basis, substantially all of our long-term care insurance policies then in-force. The following is a summary of the reinsurance agreement and is qualified in its entirety by reference to the reinsurance agreement which has been filed with the Securities and Exchange Commission. The agreement is subject to certain coverage limitations and an aggregate limit of liability which may be reduced if we are unable to obtain premium rate increases. This agreement does not qualify for reinsurance treatment in accordance with GAAP because the agreement does not result in the reasonable possibility that the reinsurer may realize a significant loss. This is due to a number of factors related to the agreement, including experience refund provisions, expense and risk charges that will be credited against our notional experience account by the reinsurer and the aggregate limit of liability. However, this agreement meets the requirements to qualify for reinsurance treatment under statutory accounting rules.

The initial premium paid by us under the agreement was approximately $619 million, comprised of $563 million of cash and securities, and $56 million held as funds due to the reinsurer. Such withheld funds are scheduled to be released to the reinsurer in increments between December 31, 2003 and December 31, 2008, subject to Centre Solutions (Bermuda) Limited s right to demand that the withheld funds be released in their entirety at any time by giving us fifteen business days prior written notice. We released $10 million during both 2003 and 2004. 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 also receives 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.

For each of the first seven years of the reinsurance agreement, Centre Solutions (Bermuda) Limited will assess against our notional experience account an annual base fee of $2.8 million plus 0.4% of the statutory reserves ceded to it. Thereafter, the fees rise to a maximum in year twelve and each year thereafter of $5.4 million plus 0.8% of the statutory reserves ceded to it. In addition, the fees include amounts for capital to support the business, and certain brokerage, maintenance and asset security fees. These fees are to be deducted from the notional experience account on a quarterly basis and are not payable to the reinsurer until, and if, the agreement is commuted.

We receive a monthly payment based on a yearly reinsurance allowance equal to (1) approximately 19.7% of the net premiums we submit to Centre Solutions (Bermuda) Limited, subject to certain adjustments for premium rate increases implemented in 2003 and thereafter and (2) 3.5% of certain incurred net losses and statutory claim reserves. The yearly reinsurance allowance is not permitted to exceed 25% of the net premiums received in the applicable calendar year. We also received a fixed amount of $2 million for each of the 2002 and 2003 calendar years and we will pay $1.2 million for each of the 2004, 2005, 2006 and 2007 calendar years.

The reinsurance agreement excludes certain losses from coverage, including liabilities arising from (1) our actions or failure to act, (2) insolvency funds, (3) nuclear hazards, (4) terrorism and (5) war or military action.

The reinsurance agreement is subject to certain coverage limitations, including an aggregate limit of liability, which is the sum of (1) $200 million, (2) the initial premium of approximately $619 million, (3) net premiums received and retained by the reinsurer on or after December 31, 2001, less reinsurance allowance and taxes related to such premiums, and (4) 4.5% of (1) through (3), less certain losses and rate increase shortfalls as described below.

The reinsurance agreement requires us to review the performance of our policies to compare their actual to expected loss experience at least every six months and to conduct an analysis of our underlying actuarial assumptions to ascertain the future morbidity experience at least once a year. If we have reason to believe that future experience is likely to be worse than projected at the later of December 31, 2001 or the date of the most recent rate increase approval, and that such deterioration in expected experience would justify an increase in premium rates of 5% or more on any individual policy form, we are required to file for and obtain increases in premium rates. Failure to obtain such increases would constitute a breach under the agreement, resulting in a reduction in the aggregate limit of liability. We are currently in compliance with the agreement.

The reinsurance agreement contains commutation provisions and allows us to recapture the reserve liabilities and the notional experience account balance as of (1) a change in control of our subsidiaries, PTNA or ANIC, (2) an insolvency of either of these subsidiaries, (3) our material breach of the reinsurance agreement, or (4) December 31, 2007 or December 31 of any year thereafter. We intend to commute the reinsurance agreement on December 31, 2007; and, for GAAP purposes, we are accounting for the reinsurance agreement in anticipation of this commutation. In the event we do not commute the reinsurance agreement on December 31, 2007, we will be subject to escalating expenses and a fourth tranche of warrants held by Centre Solutions (Bermuda) Limited will become exercisable for convertible preferred stock that, if converted, would represent approximately 20% of our outstanding common stock following such conversion on a fully diluted basis (and, together with the three other tranches of warrants, if exercised, would represent approximately 35% of the outstanding common stock following such conversion on a fully diluted basis).

Our current modeling and actuarial projections suggest that it is probable that we will be able to commute the agreement, as planned, on December 31, 2007. In order to commute the agreement, our statutory capital following commutation must be sufficient to support the reacquired business in compliance with all statutory requirements. Upon commutation, we would receive cash or other liquid assets equaling the value of our notional experience account from the reinsurer. We would also record the necessary reserves for the recaptured business in our statutory financial statements. Our ability to commute the agreement is highly dependent upon the market value of the notional experience account exceeding the level of required reserves to be established. As of December 31, 2004, the statutory reserve liabilities of $1,026,341 exceeded the value of the notional experience account and funds held due to the reinsurer of $939,452. In addition to the performance of the reinsured policies from now until 2007, the notional experience account value is susceptible to market interest rate changes. A market interest rate increase of 100 basis points could reduce the market value of the current notional experience account by approximately $110 million and jeopardize our ability to commute as planned. As we approach the intended commutation date, the sensitivity of our notional experience account to market interest rate movement will decline as the duration of the benchmark indices becomes shorter. However, the amount of assets susceptible to such interest sensitivity will continue to grow as additional net cash flows are added to the notional experience account balance prior to commutation. We intend to give notice to the reinsurer of our intention to commute on December 31, 2007 at such time as we are highly confident of our ability to support the recaptured policies. The reinsurer has agreed to fix the market value of the notional experience account upon such time of notice, and to then invest the assets in a manner that we request in order to minimize short term volatility.

As part of our reinsurance agreement, effective December 31, 2001, the reinsurer was granted four tranches of warrants to purchase shares of non-voting convertible preferred stock. The first three tranches of warrants are exercisable through December 31, 2007 at common stock equivalent prices ranging from $2.75 to $6.25 per share. If exercised and converted, the convertible preferred stock would represent approximately 15% of the then outstanding shares of our common stock on a fully diluted basis. If the agreement is not commuted on December 31, 2007, the reinsurer may exercise the fourth tranche of convertible preferred stock purchase warrants at a common stock equivalent price of $1.80 per share, which if converted would represent an additional 20% of the then outstanding common stock on a fully diluted basis. We are recognizing the additional consideration of entering into the agreement, represented by the fair value of the warrants granted to the reinsurer, over the period of time to the expected commutation date.

As a result of our intention to commute, we considered only the expense and risk charges anticipated prior to the commutation date in our DAC recoverability analyses and have not recorded the potential of future escalating charges. In the event we determine that commutation of the reinsurance agreement is unlikely on December 31, 2007, but likely at some future date, we will include additional annual expense and risk charge credits against our notional experience account in our DAC recoverability analysis. As a result, we could impair the value of our DAC asset and record the impairment in our financial statements.

The reinsurance agreement also granted the reinsurer an option to participate in reinsuring new business sales on a quota share basis. In August 2002, the reinsurer exercised its option to reinsure up to 50% of future sales, subject to a limitation of the reinsurer s risk. In 2004 and 2003, approximately $3.4 million and $2.6 million of newly issued premium was subject to this agreement, respectively.

On March 29, 2004, the reinsurer notified us of its decision to cease reinsuring newly issued policies on or after August 1, 2004. Our agreement with the reinsurer to reinsure existing policies issued prior to December 31, 2001 and policies issued under the 2002 Centre Agreement prior to August 1, 2004, are unaffected by the determination made by the reinsurer regarding newly issued policies.

Other Reinsurance

We purchase reinsurance to increase the number and size of the policies we may underwrite and as a tool to manage statutory surplus strain associated with new business growth. 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 have entered into a reinsurance agreement with General and Cologne Life Re of America (Cologne) with respect to home health care policies with benefit periods exceeding 36 months. No new policies have been reinsured under this agreement since 1998. Cologne has notified us that they believe we are in breach of our current agreement as a result of entering our agreement for existing policies with Centre Solutions (Bermuda), Inc. without the prior written approval of Cologne. We have contested this assertion of breach and are continuing discussions with Cologne to reach an equitable resolution, including, but not limited to, arbitration, the recapture of the excess home health care coverage and reserves, premium rate increases or additional reinsurance business in the future. Further, we believe that the agreement does not allow for unilateral cancellation in the event of breach. Reinsurance recoverables related to this treaty were $11.2 million and $10.6 million at December 31, 2004 and 2003, respectively.

In addition to the reinsurance agreement to cede certain home health care claims beyond 36 months, we are also party to a coinsurance agreement with Cologne on a previously acquired block of long-term care business, whereby 66% is ceded to a third party. Cologne has also claimed breach of this agreement. However, the agreement did not require prior written approval to enter other reinsurance agreements and we believe that any claim of breach is baseless.

We also have an agreement with Cologne to cede certain home health and nursing home claims. The claims ceded are either in excess of 60 months, $250,000 or $350,000 depending on the policy type. Cologne has also claimed breach of this agreement. However, none of the reinsured policies were ceded to Centre Solutions (Bermuda), Inc. and we believe any claim of breach is baseless.

We have an agreement with Lincoln Heritage Life Insurance Company to cede 100% of certain whole life and deferred annuity policies on an assumption basis effective December 31, 2002. Upon approval from state insurance departments in which the policies were issued, or policyholder approval as may be prescribed by state regulation, we will no longer record these policies in our financial statements. No gain or loss was recognized from the cession of these policies to the new insurer.

In 2001, we ceded substantially all of our disability policies to Assurity Life Insurance Company on a 100% quota share assumption basis. The reinsurer may assume ownership of the policies as a sale upon various state and policyholder approvals.

The following table shows our historical use of reinsurance:

Company	A.M. Best Rating	Reinsurance Recoverable December 31, 2004	Reinsurance Recoverable December 31, 2003
		(in thousands)	
General and Cologne Life Re of American	A+	$ 17,193	$ 16,907
Assurity Life Insurance Company	A-	3,264	3,681
Lincoln Heritage Life Insurance Company	B++	2,862	2,923
Other (1)		99	423

(1) Reinsurance recoverables of less than $500 are combined.

(h) Investments

We have categorized all of our investment securities as available for sale because 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 total shareholders equity on the balance sheet. As of December 31, 2004, shareholders equity was increased by $147,000 due to unrealized gains of $226,000 in the investment portfolio. The amortized cost and estimated market value of our available for sale investment portfolio as of December 31, 2004 and 2003 are as follows (amounts in thousands):

	December 31, 2004			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Market Value
U.S. Treasury securities and obligations of U.S Government authorities and agencies	$ 34,795	$ 298	$ (237)	$ 34,856
Mortgage backed securities	1,874	21	(16)	1,879
Debt securities issued by foreign governments	384	20	(2)	402
Corporate securities	21,892	245	(103)	22,034
	$ 58,945	$ 584	$ (358)	$ 59,171

	December 31, 2003			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Market Value
U.S. Treasury securities and obligations of U.S Government authorities and agencies	$ 20,699	$ 624	$ (38)	$ 21,285
Mortgage backed secuities	2,020	39	(3)	2,056
Debt securities issued by foreign governments	236	11	(2)	245
Corporate securities	19,978	375	(86)	20,267
	$ 42,933	$ 1,049	$ (129)	$ 43,853

Our investment portfolio, excluding our notional experience account, consists primarily of investment grade fixed income securities. Income generated from this portfolio is largely dependent on prevailing levels of interest rates at the time of original purchase. Due to the duration of our investments (approximately 4 years), investment income does not immediately reflect changes in market interest rates.

In connection with our 2001 reinsurance agreement with Centre Solutions (Bermuda) Limited, during the first quarter of 2002, we transferred substantially our entire investment portfolio to the reinsurer as the initial premium payment. The initial and future premium for the reinsured policies, less claims payments, ceding commissions and risk charges is credited to a notional experience account, the balance of which also receives an investment credit. The notional experience account balance represents an amount to be paid to us in the event of commutation of the agreement. We believe that the notional experience account represents a hybrid instrument, containing both a fixed debt host contract and an embedded derivative. The economic characteristics and risks of the embedded derivative instrument are not clearly and closely related to the economic characteristics and risks of the fixed debt host contract. We are accounting for the investment credit received on the notional experience account as follows:

1. The fixed debt host yields a fixed return based upon the yield to maturity of the underlying benchmark indices. The return on the fixed debt host is reported as investment income in the Statements of Income and Comprehensive Income.

2. The change in fair value of the embedded derivative represents the percentage change in the underlying indices applied to the notional experience account, similar to that of an unrealized gain/loss on a bond. The change in the fair value of the embedded derivative is reported as a market gain or loss on notional experience account in the Statements of Income and Comprehensive Income.

As a result, our results of operations are subject to significant volatility. The benchmark indices are comprised of United States treasury strips, agencies and investment grade corporate bonds, with weightings of approximately 25%, 15% and 60%, respectively, and have a duration of approximately 14 years.

(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, which differ from the presentation under GAAP and which also differ from the presentation under statutory accounting rules for purposes of demonstrating compliance with statutorily mandated loss ratios.

	Year ended December 31,		
	2004	**2003**	**2002**
Loss Ratio (1) (4)	69.6%	67.3%	75.8%
Expense ratio (2) (4)	52.1%	57.6%	(8.2)%
Combined loss and expense ratio	121.7%	124.9%	67.6%
Persistency (3)	88.7%	88.1%	82.8%

(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, net of ceding allowances from reinsurers, divided by collected premiums.

(3)We measure persistency as the continuation of a benefit unit, or an increment of $10 of coverage per day offered under a policy, that remains in-force from one year to the next. We selected this method rather than measuring renewing policies or premium revenue due to the impact of premium rate increases we have implemented. We believe that the higher premium revenue following a premium rate increase would distort the actual persistency of the policies in-force. In addition, we have offered policyholders affected by premium rate increases a choice of accepting the higher premium or reducing existing benefits and continuing at their original premium amount, which, if persistency was measured on renewing policies, would yield an inaccurate measure of our continuing liability.

(4)The 2004, 2003 and 2002 loss ratios and expense ratios are significantly affected by the reinsurance of approximately $303 million, $309 million and $326 million, respectively, in premium revenue on a statutory basis under financial and other reinsurance treaties. Change in reserves is accounted for as offsetting negative benefits and negative premium, causing substantial deviation in reported ratios.

Statutory accounting practices. State insurance regulators require our insurance subsidiaries to have statutory surplus at a level sufficient to support existing policies and new business growth. Under statutory accounting rules, we charge costs associated with sales of new policies against earnings as such costs are incurred. These costs, together with required reserves, generally exceed first year premiums and, accordingly, cause a reduction in statutory surplus during periods of increasing first year sales. The commissions paid to agents are generally higher for new policies than for renewing policies. Because statutory accounting requires commissions to be expensed as paid, rapid growth in first year policies generally results in higher expense ratios.

(j) Insurance Industry Rating Agencies

Our insurance subsidiaries have A.M. Best financial strength ratings of B- (fair) and Standard & Poor s claims paying ability ratings of B- (weak), with positive outlook. 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. Penn Treaty also has a financial strength rating of CCC- (weak) from Standard & Poor s for its subordinated convertible debt, but has no rating from A.M. Best. 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 insurer ratings are based upon factors of concern to policyholders and insurance agents, 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 higher financial strength rating. 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.

(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.

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 field marketing organizations 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 field marketing organizations.

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 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

General